Course: Women and Health (877)
Semester: Spring, 2022

ASSIGNMENTS NO.2

Q.1 Define violence against women. Explain the types of violence against women.

Violence against women does not mean only physical violence. It is much broader and includes sexual, emotional, psychological and financial abuse. The National Plan targets two main types of violence against women – domestic and family violence, and sexual assault.

On an international level, the United Nations Declaration on the Elimination of Violence against Women provides the following definition:

'The term violence against women means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.'

The laws in each Australian state and territory have their own definitions. While there is no single definition, the central elements of **domestic violence** include:

- acts of violence that occur between people who have, or have had, an intimate relationship;
- an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal; and
- the threatening or violent behaviour can comprise of physical, sexual, emotional, psychological and financial abuse.

Physical violence can include slaps, shoves, hits, punches, pushes, being thrown down stairs or across the room, kicking, twisting of arms, choking, and being burnt or stabbed.

Psychological and emotional abuse can include a range of controlling behaviours such as control of finances, isolation from family and friends, continual humiliation, threats against children or being threatened with injury or death.

Financial or economic abuse includes forcibly controlling another person's money or other assets. It can also involve stealing cash, not allowing a victim to take part in any financial decisions or preventing a victim from having a job.

Family violence is a broader term that refers to violence between family members, as well as violence between intimate partners. It involves the same sorts of behaviours as described for domestic violence. As with domestic violence, the National Plan recognises that although only some aspects of family violence are criminal offences, any behaviour that causes the victim to live in fear is unacceptable. The term 'family violence' is the most widely used term to identify the experiences of Aboriginal and Torres Strait Islander people, because it includes the broad range of marital and kinship relationships in which violence may occur.

Sexual assault or **sexual violence** can include rape, sexual assault with implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with friends of the perpetrator.

Research has demonstrated that violence against women often involves a continuum of violence from psychological, economic and emotional abuse through to physical and sexual violence.

What are the causes?

Many of the misconceptions surrounding violence again women centre on its causes. There are a number of myths that exist, such as:

- men can't control their anger or sexual urges;
- alcohol causes men to be violent;
- women could leave violent partners if they wanted to; and
- men experience equal, if not greater, levels of violence perpetrated by their partners or former partners.

Research has shown that the significant drivers of violence against women include:

- the unequal distribution of power and resources between men and women; and
- an adherence to rigidly defined gender roles and identities i.e., what it means to be masculine and feminine.

Attitudes that condone or tolerate violence are recognised as playing a central role in shaping the way individuals, organisations and communities respond to violence. VicHealth has summarised five key categories of violence supportive attitudes that arise from research. These include attitudes that:

- justify violence against women, based on the notion that it is legitimate for a man to use violence against a woman;
- excuse violence by attributing it to external factors (such as stress) or proposing that men cannot be held fully responsible for violent behaviour (for example, because of anger or sexual urges);
- trivialise the impact of violence, based on the view that the impacts of violence are not serious or are not sufficiently serious to warrant action by women themselves, the community or public agencies;
- minimise violence by denying its seriousness, denying that it occurs or denying that certain behaviours are indeed violence at all; and
- shift blame for the violence from the perpetrator to the victim or hold women at least partially responsible for their victimisation or for preventing victimisation.

Q.2 Discuss the feminist approaches to prostitution in the light of Barbra Sullivan's article. Give your won critical views on this issue.

There exists a diversity of **feminist views on prostitution**. Many of these positions can be loosely arranged into an overarching standpoint that is generally either critical or supportive of prostitution and sex work.[1] The discourse surrounding prostitution is often discussed assuming sex workers are women, but those in the field of sex work and prostitution are not always women.

Anti-prostitution feminists hold that prostitution is a form of exploitation of women and male dominance over women and a practice which is the result of the existing patriarchal societal order. These feminists argue that prostitution has a very negative effect, both on the prostitutes themselves and on society as a whole, as it reinforces stereotypical views about women, who are seen as sex objects which can be used and abused by men.

Pro-prostitution feminists hold that prostitution and other forms of sex work can be valid choices for women and men who choose to engage in it. In this view, prostitution must be differentiated from forced prostitution, and feminists should support sex worker activism against abuses by both the sex industry and the legal system.

The disagreement between these two feminist stances has proven particularly contentious, and may be comparable to the feminist sex wars (acrimonious debates on sex issues) of the late twentieth century.

Newman and White in Women Power and Public Policy (2012) argue that feminist perspectives on prostitution agree on three main points: "First, they condemn the current legal policy enforcing criminal sanctions against women who offer sex in exchange for money. Second, they agree that authentic consent is the sine qua non of legitimate sex, whether in commercial or non-commercial form. Third, all feminists recognize that commercial sex workers are subject to economic coercion and are often victims of violence, and that little is done to address these problems."[3]:247

They go on to identify three main feminist views on the issue of prostitution. The sex work perspective, the abolitionist perspective and the outlaw perspective. The sex work perspective maintains that prostitution is a legitimate form of work for women faced with the option of other bad jobs, therefore women ought to have the right to work in the sex trade free of prosecution or the fear of it. The sex work perspective also argues that governments should eliminate laws that criminalize voluntary prostitution. This, the sex work perspective asserts, will allow prostitution to be regulated by governments and business codes, protect sex trade workers, and improve the ability to prosecute people who hurt them. The abolitionist perspective holds that governments should work towards the elimination of prostitution. The outlaw perspective views work in the sex trade as a "stepping stone to a better career or an expression of sexual freedom".

These feminists argue that, in most cases, prostitution is not a conscious and calculated choice. They say that most women who become prostitutes do so because they were forced or coerced by a pimp or by human trafficking, or, when it is an independent decision, it is generally the result of extreme poverty and lack of opportunity, or of serious underlying problems, such as drug addiction, past trauma (such as child sexual abuse), and other unfortunate circumstances.

These feminists point out that women from the lowest socio-economic classes—impoverished women, women with a low level of education, women from the most disadvantaged racial and ethnic minorities—are over-represented in prostitution all over the world; as stated by Catherine MacKinnon: "If prostitution is a free choice, why are the women with the fewest choices the ones most often found doing it?".[10][11] A large percentage of prostitutes polled in one study of 475 people involved in prostitution reported that they were in a difficult period of their lives and most wanted to leave the occupation.[12] MacKinnon argues that "In

prostitution, women have sex with men they would never otherwise have sex with. The money thus acts as a form of force, not as a measure of consent. It acts like physical force does in rape."[13]

Some anti-prostitution scholars hold that true consent in prostitution is not possible. Barbara Sullivan says: "In the academic literature on prostitution, there are very few authors who argue that valid consent to prostitution is possible. Most suggest that consent to prostitution is impossible, or at least unlikely."[14] "[...] most authors suggest that consent to prostitution is deeply problematic, if not impossible [...] most authors have argued that consent to prostitution is impossible. For radical feminists, this is because prostitution is always a coercive sexual practice. Others simply suggest that economic coercion makes the sexual consent of sex workers highly problematic, if not impossible..."

Finally, abolitionists believe no person can be said to truly consent to their own oppression, and no people should have the right to consent to the oppression of others. In the words of Kathleen Barry, consent is not a "good divining rod as to the existence of oppression, and consent to violation is a fact of oppression. Oppression cannot effectively be gauged according to the degree of 'consent', since even in slavery, there was some consent, if consent is defined as inability to see any alternative."

Long-term effects on the prostitutes

Anti-prostitution feminists argue that prostitution is a practice which leads to serious negative long-term effects for the prostitutes, such as trauma, stress, depression, anxiety, self-medication through alcohol and drug use, eating disorders and a greater risk for self-harm and suicide, as they say prostitution is an exploitative practice, which involves a woman who has sex with customers to whom she is not attracted, and which also routinely exposes the women to psychological, physical and sexual violence.

Andrea Dworkin stated her opinions as: "Prostitution in and of itself is an abuse of a woman's body. Those of us who say this are accused of being simple-minded. But prostitution is very simple. In prostitution, no woman stays whole. It is impossible to use a human body in the way women's bodies are used in prostitution and to have a whole human being at the end of it, or in the middle of it, or close to the beginning of it. It's impossible. And no woman gets whole again later, after."

Anti-prostitution feminists are extremely critical of sex-positive perspectives, wherein prostitution by choice is said to be part of the sexual liberation of women, that it can be empowering for women, etc.[citation needed] Some feminists who oppose prostitution agree that sexual liberation for women outside of prostitution is important in the fight for gender equality, but they say it is crucial that society does not replace one patriarchal view on female sexuality – e.g., that women should not have sex outside marriage/a relationship and that casual sex is shameful for a woman, etc. – with another similarly oppressive and patriarchal view – acceptance of prostitution, a sexual practice which is based on a highly patriarchal construct of sexuality: that the sexual pleasure of a woman is irrelevant, that her only role during sex is to submit to the man's sexual demands and to do what he tells her, that sex should be controlled by the man and that the woman's response and satisfaction are

irrelevant. These feminists argue that sexual liberation for women cannot be achieved as long as we normalize unequal sexual practices where a man dominates a woman.[21]

Such feminists see prostitution as a form of male dominance over women, as the client has sex with a woman who does not enjoy it and who may be making a tremendous psychological effort to mentally dissociate herself from the client. They say that the act of prostitution is not a mutual and equal sex act as it puts the woman in a subordinate position, reducing her to a mere instrument of sexual pleasure for the client. These feminists believe that many clients use the services of prostitutes because they enjoy the "power trip" they derive from the act and the control they have over the woman during the sexual activity. Catharine MacKinnon argues that prostitution "isn't sex only, it's you do what I say, sex."

Prostitution is seen by these feminists as the result of a patriarchal societal order which subordinates women to men and where the inequality between genders is present in all aspects of life. These feminists believe that prostitution is very harmful to society as it reinforces the idea that women are sex objects which exist for men's enjoyment, which can be "bought" and which can be "used" solely for men's sexual gratification. Anti-prostitution feminists argue that when a society accepts prostitution it sends the message that it is irrelevant how the woman feels during sex or what the consequences of sex will be for her, and that it is acceptable for a man to engage in sexual activity with a woman who does not enjoy it and who could be mentally and emotionally forcing herself to be able to cope; the normalization of such one sided sexual encounters might negatively affect the way men relate to women in general and might increase sexual violence against women.

These feminists see prostitution as a form of slavery, and say that, far from decreasing rape rates, prostitution leads to a sharp increase in sexual violence against women, by sending the message that it is acceptable for a man to treat a woman as a sexual instrument over which he has total control. Melissa Farley argues that Nevada's high rape rate is connected to legal prostitution because Nevada is the only US state which allows legal brothels and is ranked 4th out of the 50 U.S. states for sexual assault crimes, saying, "Nevada's rape rate is higher than the U.S. average and way higher than the rape rate in California, New York and New Jersey. Why is this? Legal prostitution creates an atmosphere in this state in which women are not humans equal to them, are disrespected by men, and which then sets the stage of increased violence against women."

Q.3 Discuss in detail the double discrimination of women with disabilities (1990) in the light of Rannvieg Transtadotlir research article.

Women with disabilities are twice as likely to be victims of domestic violence as other women. .Based on this finding,Handicap International has decided to highlight their plight when it takes the floor at the 57th United Nations Commission on the Status of Women, on International Women's Day. According to Muriel Mac-Seing, Technical Advisor on gender based violence at Handicap International, "Women with disabilities often face double discrimination. It's our duty to bring this injustice to an end."

Although women with disabilities represent 19.2% of the global female population and often live in precarious conditions, they receive too little attention. Yet the few studies devoted to disability and gender-based violence

all highlight the vulnerability of women and girls with disabilities to various forms of violence. Eighty per cent of women with disabilities living in rural Asia, for example, are unable to meet their own needs[2]and are heavily dependent on family and friends. Handicap International's field experience also shows that women and girls with disabilities are at a heightened risk of violence and remain excluded from basic services, such as education, health, work and social support.

Violence People with disabilities are 130% more likely to be survivors of violence than people without disabilities. It is also widely acknowledged that women with disabilities are at a heightened risk of sexual violence and twice as likely to experience domestic violence. "Women are much more likely to experience sexual violence if they have an impairment because they generally live in closer contact with adult members of their family, on whom they are often dependent, and because social and cultural stereotypes dictate that women and girls do not have the right to manage their own sexual and reproductive health," explains Muriel Mac-Seing, HIV and AIDS/Protection Technical at Handicap International.

"African women in rural areas for example, are often sexually abused and their families, who often know about it or are involved in such abuse, stay silent about it due to fear of further discrimination and stigmatisation. They start from the premise that women and girls with disabilities do not have rights and cannot refuse to engage in a sexual act, even if a man is drunk, aggressive or HIV positive. Sexually transmitted infection such as HIV and unwanted pregnancies are major consequences of gender-based violence for women with disabilities."

"Sometimeswomen and girls with disabilities are forcibly sterilised and pushed into terminating pregnancies, based on the paternalistic reasoning that 'it's for their own good'," says Muriel. One study conducted by the United Nations has revealed that in Orissa, India, 6% of women with disabilities have been sterilised against their will.

Discrimination and stigmatisation "Women and girls with disabilities are at risk of more than direct violence," underlines Muriel. "They are often excluded from basic services, such as health and education, or do not have the right to work." A Handicap International study in the Western Province of Rwanda revealed a vicious spiral at work: women who are prevented from exercising their right to attend school are more likely to remain ignorant of their rights and to put up with degrading and violent treatment. Their economic vulnerability, which is linked to their gender and disability, also creates an environment in which they are more likely to be ill-treated, leading to further impoverishment of affected people with disabilities as well as their families.

Taking action "Combating violence against women and girls with disabilities must be one of the United Nation's top priorities," says Muriel, on behalf of the International Disability and Development Consortium (IDDC), who is scheduled to speak on 11 March at the 57th United Nations Commission on the Status of Women, which will be held in New York between 4 and 15 March. The IDDC will use this opportunity to recommend a number of recommendations, including equal access to gender-based violence related services. "All too often service providers working on gender-based violence do not gather specific information on people

with disabilities and do not have the skills to provide an appropriate and accessible response to women and girls with disabilities," explains Muriel.

This is also the case in disaster situations. "During disaster situations, for example in refugee camps, women with disabilities are extremely vulnerable," explains Hélène Robin, manager of Handicap International's emergency programmes. "Not only are services poorly adapted to their specific needs (they cannot move around and do not have access to food distributions or latrines, for example), they are also at a heightened risk of violence. This is why Handicap International ensures that vulnerable people, including pregnant and isolated women, have access to care services and distributions to avoid their situation getting even worse."

"Moreover, women with disabilities in emergency situations are most likely to suffer from intellectual, sensorial or psychological impairments. Women who are deaf and mute, for example, cannot call for help, when necessary, or express their needs, because they are unlikely to be fully understood (which makes them priority targets). At the same time, women who are the victims of violence or abuse, but who have an intellectual impairment or mental health problems, may be considered to be unreliable witnesses. These women therefore need particular protection during emergency situations."

- Violence against Women Report, 2012, United Nations
- Economic and Social Commission for Asia and the Pacific, Bangkok, 2003
- Lisa Jones and Al., Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies, The Lancet, 12/06/2012.
- 70% of women are victims of violence during their lifetime; 50% of sexual abuse is perpetrated against girls aged under 16 (source: UN Women, 2013)

Q.4 Compare the health of women in jails/prisons with the health of refugee women in detail. What are the main issues which you think must be should be addressed on priority basis?

The health of prisoners is among the poorest of any population group and the apparent inequalities pose both a challenge and an opportunity for country health systems. The high rates of imprisonment in many countries, the resulting overcrowding, characteristics of prison populations and the disproportionate prevalence of health problems in prison should make prison health a matter of public health importance.

Women prisoners constitute a minority within all prison systems and their special health needs are frequently neglected. The urgent need to review current services is clear from research, expert opinion and experience from countries worldwide. Current provision of health care to imprisoned women fails to meet their needs and is, in too many cases, far short of what is required by human rights and international recommendations. The evidence includes a lack of gender sensitivity in policies and practices in prisons, violations of women's human rights and failure to accept that imprisoned women have more and different health-care needs compared with male prisoners, often related to reproductive health issues, mental health problems, drug dependencies and

histories of violence and abuse. Additional needs stem from their frequent status as a mother and usually the primary carer for her children.

National governments, policy-makers and prison management need to address gender insensitivity and social injustice in prisons. There are immediate steps which could be taken to deal with public health neglect, abuses of human rights and failures in gender sensitivity.

Worldwide, more than 500 000 women and girls are held in penitentiary institutions, either as pre-trial detainees or sentenced prisoners. They constitute a small proportion of the total prison population; in about 80% of prison systems worldwide, the proportion of women varies between 2% and 9% with a median of 4.3% in 2006. Women who enter prison usually come from marginalized and disadvantaged backgrounds and are often characterized by histories of violence, physical and sexual abuse. Disadvantaged ethnic minorities, foreign nationals and indigenous people constitute a larger proportion of the female prison population relative to their proportion within the general community, often due to the specific problems these vulnerable groups face in society.

Women prisoners are a small minority of the total prison population but there has been a noticeable rise in women's imprisonment in recent years. In some countries the rate of this increase has been higher than that of male prisoners. For instance in England and Wales, the number of imprisoned women has increased by more than 200% in the past 10 years, compared with a 50% increase in the number of imprisoned men during the same period.

Since their foundation, prisons have been built and run to cope with the needs of the male majority. Until recent times, the small numbers of women prisoners were simply admitted to the same prisons and were expected to cope with the same routines and facilities as men. Lack of attention to the very different and often more complex needs of women has resulted in neglect of their human rights, disregard to international recommendations and many instances of social injustice. In a world where there are widespread and persistent inequities between women and men, societies continue to fail to meet the health needs of women at key moments of their lives. A review of gender equity in health states that the present position is "unequal, unfair, ineffective and inefficient"

The small numbers of imprisoned women mean that there are fewer prisons for them, resulting in women often being imprisoned further away from their homes. This causes difficulties for the woman in maintaining her family ties and is especially a problem if she has dependent children. Many imprisoned women are mothers and usually primary or sole carers for their children.[6] When a mother is imprisoned, her family will often break up, resulting in many children ending up in state care institutions or alternative care. Imprisonment far from home also complicates a woman's resettlement after release. The small number of women prisons also results in the collective accommodation of women convicted for a wide range of offences in a prison with a high level of security, needed only for very few women. In fact, by far the majority of offences for which women are imprisoned are non-violent, property or drug related for which they serve short sentences. A high security level

is disproportionate to the risk they pose. Drug-related offences (usually for personal use) are one of the most common crimes committed by women.

Q.5 Write notes on the following:

a) NGO's & Women Health Issue.

Traditionally non-governmental organizations (NGOs) have always been in the forefront of promoting new ideas and in encouraging governments to implement them. At all levels - local, national and international - NGOs represent the 'voice of the people'. They have taken on roles such as advocacy, education and training, and have been active in monitoring what has, or has not, been achieved. During the past two decades NGOs have actively advocated that the fullest recognition should be given to the enormous contribution that women make to the family, society and development. NGOs have been among the strongest advocates for implementation of the outcomes of the series of UN world conferences on women which began with the International Women's Year Conference held in Mexico City in 1975.

Developing the concept of a gender approach from an NGO perspective

Much of the major debate on women's issues among NGOs during the past few years has focussed on moving from a 'women-centred' approach to a 'gender' approach particularly in the context of their contribution to development. Health has been one of the most recent issues to be approached in this way. The NGO Symposium Health for All women and men: a gender perspective, held in Geneva in October 1997, recognized that:

The concept of gender refers to women's and men's roles and relationships which are shaped by social, economic, political and cultural factors rather than by biology. Gender, moreover, is a dynamic concept which examines the nature of these roles and relationships between women and men in the context of the perspectives and beliefs of society. These socially constructed roles and relationships have a direct bearing on the health and well being of both sexes. A gender perspective helps identify the inequalities between women and men which in the field of health can lead for both to increased illness or death from preventable causes. A gender approach to health examines how gender differences determine access to benefits and the way in which technology, information, resources and health care are distributed. It provides the foundation for maximizing human resources in development because the result of equal access to resources, benefits and opportunity to all will be a more enlightened, educated, healthy and independent society. Society as a whole will therefore be better placed and equipped to contribute to development. On the contrary the denial of opportunity and access to benefits and resources to women who make up more than half the world's population will continue the inadequate use of this valuable human resource.=

NGOs, moreover, recognize that gender inequalities in many different sectors that are not readily identified as concerned with health can have an adverse effects on women's health eg

- non-involvement of women in decision-making on resource allocation for the health sector results in decisions being taken by men who may not take into account the kinds of health services that only

women will need. High maternal and infant mortality rates in particular can be attributed to the lack, or defective distribution of, resources in the health sector;

- discrimination against girl children (a) before birth through pre-natal sex selection; (b) at birth through infanticide and (c) during childhood through neglect and son preference, compounded by their unfair share of food and of domestic chores, can lead to anaemia, malnutrition and stunting of growth;
- widespread and largely unreported prevalence of violence against women, including psychological and sexual abuse can cause lasting damage to their health and is not infrequently fatal;
- women's bodies are far more susceptible to infection by sexually transmitted diseases (STDs) including HIV/AIDS, and the risk of infection is compounded by their inability to insist upon safe sex. The associated complications include infertility and even death.
- unfair share of family income received by women and girls, together with their reduced opportunities for education and training, and consequential inability to obtain gainful employment, may force them to resort to commercial sex, and increased exposure to risk of contracting STDs or HIV/AIDS;
- early arranged marriages, a practice over which the girls concerned have little or no control, can lead to too early and unspaced pregnancies with associated health risks;
- cultural practices which preclude women's rights to make their own decisions, such as female genital mutilation (to which two million girls are subjected every year) and widow inheritance can have a serious and long term effects on their health.

NGOs as advocates

One of the most important roles that NGOs undertake is advocacy. The aims and objectives of the NGOs are usually focussed on improving the lives of their constituents and the communities in which and with which they work. NGOs have, for example, been in the forefront in protecting women's rights as human rights, by exposing violence against women, by promoting the needs of the girl child and by promoting and developing a comprehensive, holistic and rights-based approach to health services for women.

In order to bring about change it is necessary to convince the key stakeholders, whether they work in government, in administration, or as providers of the necessary funding, to bring about the change. It is also necessary to ensure that the electorate understands and supports the changes which need to be made.

NGOs are well placed to promote the need for a gender approach to health care. They have become increasingly effective as advocates at all levels - local, national and international. This has been shown at international level by the activities of networks and coalitions such as Women's Caucus, Advocacy for Women's Health, and HERA at the recent series of UN inter-governmental conferences and at the five-year reviews of the conferences that are currently underway. NGOs have also been active in identifying key decision-makers, preparing position papers and lobbying documents, and in contacting the media by means of press releases and press conferences and arranging press visits and encounters.

Since most of the decision-makers in the organization and financing of health care delivery tend to be men rather than women NGOs have to a key role to play in convincing them to adopt a gender approach. At national level health professional associations can be most effective as advocates for a gender approach to health care delivery. Not only are their members likely to be among the first to be affected but they usually include among their officers individuals who are in a strong position to influence government eg the current Minister of Health for Ghana is a former Vice-President of the Ghana Medical Association, and there are several other examples. Physicians will have studied for their medical degrees alongside students in other disciplines who will have gone on to take up key decision-making positions in government. It follows that sensitisation of health professional associations should be regarded as a priority so that they can exploit their ready access to Ministries of Health and to other important opinion formers in the interests of achieving the necessary changes.

Health professional associations can also be effective in working with parliamentarians in promoting a gender approach to health care delivery. They will often seek the advice of health professional associations on issues to do with health care, because they know that medical ethics require physicians to provide objective advice on health issues in the best interests of their patients. Health professional associations recognize the importance of developing good relations with the media in their own interests and can use their contacts to promote a gender approach to health care delivery. They can also be effective in persuading the general public by which recognizes their pronouncements as being both independent of government and objective. Together with other health-concerned NGOs they can employ the skills and experience that NGOs have amassed in putting across messages to the public in a way that the public is able to understand, and this will be very necessary in promoting a gender approach to health care.

NGOs and training

Many NGOs are involved in training and training programmes, which is a role which they have traditionally undertaken at all levels. They are therefore well-placed to assist the relevant government departments in bringing about the changes which will have to be put in place to ensure a gender approach to health care. It will, for example, be important to sensitize not only health ministries, but also other ministries such as finance and planning that will have to be involved in gender-sensitivity.

Many NGOs have already developed training programmes in this area which can easily be adapted to take into account the special needs of the health sector. Health professional associations will need to sensitize their own members, who play a crucial role in the provision of health care, in order to ensure that they adopt a gender-sensitive approach at all levels of their health service activities eg it is important that they should adopt a gender-sensitive approach in working with their colleagues as many of the less-trained and less-well paid health care workers are women. It follows that NGOs should be invited by governments to assist as partners in the development of training programmes on the gender approach to health care.

NGOs as catalysts

Account has to be taken of the fact that key government departments which will have to be involved in developing a gender approach to health care are frequently male-dominated and are not usually concerned with the needs of women. In some cases they may initially be resistant to attempts to introduce a gender approach to health care delivery in the belief that it would be more advantageous to women and benefit women more than men. NGOs can act as catalysts by encouraging the various departments concerned with health to become involved. This will be more effective if different types of NGOs work together. Different NGOs have different constituencies - for example in addition to health professional NGOs there are also women's NGOs, that concentrate on activities to improve the status of women, development NGOs that focus particularly on development issues.

When a government decides to undertake a full sector-wide approach to gender sensitivity in health care it will be necessary to involve other ministries other than health that are involved in the provision of health care. health care. In countries where there is high maternal mortality and morbidity the Ministry of Transport can play an important role in ensuring that 'high-risk' women can get to hospitals to receive the necessary treatment, which is often life-saving eg in parts of Nigeria women who are suffering from obstetrical complications are often taken to the nearest main road where a passing truck has to be stopped and the driver asked to take her to the nearest hospital. When the woman arrives at the hospital the driver is paid for bringing her, thereby providing a simple solution to the problem and probably saving her life.

b) Definition and Models of Disability.

Medical Model of Disability

The medical model of disability is presented as viewing disability as a problem of the person, directly caused by disease, trauma, or other health condition which therefore requires sustained medical care provided in the form of individual treatment by professionals.

- In the medical model, management of the disability is aimed at a "cure," or the individual's adjustment and behavioral change that would lead to an "almost-cure" or effective cure.
- In the medical model, medical care is viewed as the main issue, and at the political level, the principal response is that of modifying or reforming health-care policy.

Identity Model

Disability as an identity model is closely related to the social model of disability - yet with a fundamental difference in emphasis - is the identity model (or affirmation model) of disability.

This model shares the social model's understanding that the experience of disability is socially constructed, but differs to the extent that it 'claims disability as a positive identity' (Brewer et al. 2012:5). Brewer et al. (2012) offer the following illuminating definition, which also explains how the identity model departs from the social model's approach - (http://www.scielo.org.za/pdf/hts/v74n1/06.pdf)

Social Model of Disability

The social model of disability sees the issue of "disability" as a socially created problem and a matter of the full integration of individuals into society.

In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence, the management of the problem requires social action and is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life.

The issue is both cultural and ideological, requiring individual, community, and large-scale social change. From this perspective, equal access for someone with an impairment/disability is a human rights issue of major concern.

Minority Model of Disability

The minority model of disability, also known as sociopolitical model of disability, adds to the social model, the idea that disability is imposed on top of impairment via negative attitudes and social barriers, in suggesting that people with disabilities constitute a entitative, (relating to or possessing material existence), social category that shares in common the experience of disability.

The minority model normalizes the experience of disability as a minority experience no more or less aberrant or deviant than other minority groups' experiences (sex, race, sexual orientation, etc.). Essentially, this is the assertion that people with disabilities are, in part, disabled not by what's going on with our bodies per se, but by the manner in which the able-bodied majority of society views us and either molds or does not mold itself to allow us to fit.

Expert or Professional Model of Disability

The expert or professional model of disability has provided a traditional response to disability issues and can be seen as an offshoot of the medical model.

Within its framework, professionals follow a process of identifying the impairment and its limitations (using the medical model), and taking the necessary action to improve the position of the disabled person. This has tended to produce a system in which an authoritarian, over-active service provider prescribes and acts for a passive client.

Tragedy and/or Charity Model of Disability

The tragedy and/or charity model of disability depicts disabled people as victims of circumstance who are deserving of pity.

This, along with the medical model, are the models most used by non-disabled people to define and explain disability.

Moral Model of Disability

The moral model of disability refers to the attitude that people are morally responsible for their own disability. For example, the disability may be seen as a result of bad actions of parents if congenital, or as a result of practicing witchcraft if not.

This attitude may also be viewed as a religious fundamentalist offshoot of the original animal roots of human beings when humans killed any baby that could not survive on its own in the wild. Echoes of this can be seen in the doctrine of karma in Indian religions.

Legitimacy Model of Disability

The legitimacy model of disability views disability as a value-based determination about which explanations for the atypical are legitimate for membership in the disability category. This viewpoint allows for multiple explanations and models to be considered as purposive and viable (DePoy & Gilson, 2004) (Elizabeth DePoy & Stephen Gilson).

Empowering Model of Disability

The empowering model of disability allows for the person with a disability and his/her family to decide the course of their treatment and what services they wish to benefit from. This, in turn, turns the professional into a service provider whose role is to offer guidance and carry out the client's decisions. In other words, this model "empowers" the individual to pursue his/her own goals.

Social Adapted Model of Disability

The social adapted model of disability states although a person's disability poses some limitations in an able-bodied society, oftentimes the surrounding society and environment are more limiting than the disability itself.

Economic Model of Disability

The economic model of disability defines disability by a person's inability to participate in work.

It also assesses the degree to which impairment affects an individual's productivity and the economic consequences for the individual, employer and the state. Such consequences include loss of earnings for and payment for assistance by the individual; lower profit margins for the employer; and state welfare payments. This model is directly related to the charity/tragedy model.

Diversity Model of Disability

Disability as Human Variation, an alternative model intended to focus attention on how society's systems respond to variation introduced by disability (Scotch and Shriner 1997). Under this model, accessibility in the built environment, for example, is not solely achieved by anti-discrimination regulation requiring a 'universal solution; the diversity of disability must be acknowledged (Scotch and Shriner 1997). Shriner and Scotch (2001) further question the socio-political definition of disability, in which (all) barriers faced by people with disability are (built-environment) imposed and therefore removable, feeling that this common underlying ideology of disability rights activists and independent living movements insufficiently recognizes that impairment does have a bearing on accessibility outcomes.