

# Integrating Women's Human Rights into Global Health Research: An Action Framework

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## Abstract

This article uses Scale of Change theory as a framework to guide global health researchers to synergistically target women's health outcomes in the context of improving their right to freedom, equity, and equality of opportunities. We hypothesize that health researchers can do so through six action strategies. These strategies include (1) becoming fully informed of women's human rights directives to integrate them into research, (2) mainstreaming gender in the research, (3) using the expertise of grass roots women's organizations in the setting, (4) showcasing women's equity and equality in the organizational infrastructure, (5) disseminating research findings to policymakers in the study locale to influence health priorities, and (6) publicizing the social conditions that are linked to women's diseases. We explore conceptual and logistical dilemmas in transforming a study using these principles and also provide a case study of obstetric fistula reduction in Nigeria to illustrate how these strategies can be operationalized. Our intent is to offer a feasible approach to health researchers who, conceptually, may link women's health to social and cultural conditions but are looking for practical implementation strategies to examine a women's health issue through the lens of their human rights.

## Introduction

**W**HEN HEALTH IS CONSIDERED as a human right and not a social good . . . responsibilities need to be defined.<sup>1</sup>

### *Women's health burdens*

There is urgency to decrease women's disease burdens by addressing alterable social conditions that make them more susceptible than men to poor health. ("Women" as used here also includes girls).<sup>2,3</sup> The World Health Organization (WHO)<sup>3</sup> highlights global trends that make women more prone than men to ill health. These trends include (1) widespread and persistent inequities in health services received, (2) shortened life spans because of sexual diseases and inadequate sexuality and reproductive services, (3) a high toll of chronic physical and mental diseases, with limited understanding of gendered effects of these diseases, (4) poor quality of girls' lives that later affect their health as women, and (5) multiple ways in which health systems worldwide fail women.

These global trends are associated with a host of social conditions that affect women daily, for example, their overrepresentation among the destitute and poor; early or forced marriages; unmet need for family planning; domestic and

sexual violence; cultural and religious oppression; victimization during disasters, wars, and civil unrest; lack of access to education; political disempowerment; social exclusion based on sex or race/ethnicity; and labor inequalities.<sup>4,5</sup> Worldwide, these conditions play out differentially for women in high-income and low-income countries and among more and less privileged women within countries and communities. A common scenario is that women with the fewest resources experience the worst social conditions and also the poorest health.<sup>3</sup> For decades, these social determinants of women's well-being have been targeted by global women's rights movements.

This article explores the premise that research into the etiology, diagnosis, treatment, and prevention of women's illness and also wellness (women's health research) can advance women's freedoms, equity, and equality (human rights), but this does not occur automatically. Researchers must intentionally integrate a human rights framework<sup>2</sup> into women's health research, and Scale of Change theory<sup>6-8</sup> suggests strategies for doing so. A human rights framework in women's health research begins with recognition of the social impact of studies that we hypothesize can occur at two broad levels. At a first level of impact, a study can provide tangible

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health benefits for women, such as a new clinical procedure or medication. Although individualized health outcomes improve, the existing social templates that exacerbate women's vulnerability to disease conditions, such as gender inequality and discrimination, usually remain unchanged.<sup>6-8</sup>

To improve health outcomes as well as women's human rights conditions, researchers must intentionally target a second level of impact. At this deeper level, a study provides individualized health benefits but also purposefully illuminates elements of the social and community contexts driving women's diseases, for example, cultural and social norms that disadvantage women.<sup>2,6-8</sup> We suggest practice strategies that target this deeper level of impact without necessarily requiring a huge output of financial resources. There are conceptual and practical challenges to moving research studies beyond individualized outcomes, and we acknowledge some of them. To illustrate recommended strategies, we describe a research project on obstetric fistula in Nigeria that is aimed at intensive first-level and second-level impacts. In providing these recommendations, our ultimate purpose is to facilitate a transformation of the research enterprise, using relatively straightforward strategies, to address not only women's health conditions but also their fundamental freedoms and rights.

### *Women's human rights*

Globally, women's human rights movements derive from an understanding that women's freedoms, equity, and equality of opportunities can be threatened in their home countries, communities, and families.<sup>9</sup> Women's rights are grounded first in the Universal Declaration of Human Rights (1948),<sup>10</sup> to which almost every country is a signatory. This international treatise mandates civil society institutions to enact constitutions, laws, and policies guaranteeing rights of all peoples without regard to their national and social identities, including their gender and sex. World conferences on women's rights in Mexico City (1975), Copenhagen (1980), Nairobi (1985), and Beijing (1995) reinforced rights for women as a moral, ethical, and political responsibility, which demands that women's fundamental freedom and human dignity are explicitly protected from interference in any setting worldwide.<sup>9</sup>

Around 90% of countries have also ratified other international conventions specifically banning discriminations against women, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)<sup>11</sup> and the Declaration on the Elimination of Violence against Women (1993).<sup>12</sup> Regional commitments, such as the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol, 2003),<sup>13</sup> also enshrine similar principles. In these documents, discrimination is viewed as any: "exclusion or restriction made on the basis of sex which has the effect . . . of impairing or nullifying the recognition, enjoyment or exercise by women . . . of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." Thus, social conditions that lead to treating women as second-class citizens relative to men are to be illuminated and dismantled.

Other international commitments focus specifically on human rights associated with important aspects of health. For example, the International Consensus Statement on Women's Mental Health and Consensus Statement on Interpersonal

Violence<sup>14</sup> call for governments, professional health and mental organizations, providers, the United Nations, and WHO to integrate social and psychological health policies into program planning across women's life contexts and to reduce mental health distresses brought on by interpersonal violence worldwide. At the International Conference on Population and Development (Cairo, 1994), over 179 countries ratified a Program of Action recognizing women's reproductive health and rights as well as women's empowerment and gender equality as cornerstones of population progress and development.<sup>15</sup>

In these international and regional commitments, improvement in women's human rights are directly and indirectly linked to improving their health.<sup>2,9</sup> For example, CEDAW recommendation Number 24 (1999) presents women's human rights and health rights as interconnected, recommendation Number 21 (1994) identifies the importance of equality in marriage and family relations in improvements in women's reproductive health, and recommendation Number 19 (1992) recognizes violence against women as a serious worldwide condition leading to women's injuries and deaths.<sup>2,9</sup> In sum, a major tenet of these commitments is that the health and disease of women must be viewed through a human rights lens, which is also our belief. Taking this perspective, researchers have an obligation, not just an option, to thoughtfully consider women's overall social standing as they target health conditions in study settings.

Whereas some researchers, such as De Negri Filho,<sup>16</sup> theoretically or conceptually link women's health status and the social conditions they face, in practice, most pay scant attention to an obligation to design health research to address social violations driving diseases.<sup>17-19</sup> In our experience, health researchers are generally uninformed of global women's human rights directives and efforts at reforms in local settings. Individualized health improvements are often considered as the social good emanating from the research, with little consideration of any moral and ethical obligation, as mandated in human rights documents, to address gender inequalities that deepen women's vulnerability to diseases.<sup>19</sup> To narrow the divide, we propose that studies be recast from a women's human rights framework where researchers intentionally target women's illnesses and also discriminatory social circumstances.<sup>2</sup> To transform studies along these lines, we offer an action framework and strategies.

### *Deepening the social impact of health research*

Scale of Change theory<sup>6-8</sup> has guided organizations to strategically transform their operation for deeper social and cultural impact and is a useful action framework to simultaneously address women's health and human rights outcomes. Scale in this theory refers to the depth or breath of change an organization can bring about by strategic actions, which can be deep, that is, altering core templates of social relations in a system, or wide, that is, a deep change diffused over additional populations and contexts.<sup>6-8</sup> We focus on the deep social changes a study can bring about. We are not just advocating strategic changes in which an organization might plan, redesign, and implement woman-friendly services that improve healthcare. Such changes are quite laudable but may be contained within a health system itself. Our focus is on actions that impact the broader contexts that make up the

social fabrics of women's lives, as this hypothetical example of HIV and antiretroviral therapy (ART) is used to illustrate.

A study might examine the effect of ART on girls and women newly diagnosed with HIV with the aim of improving their quality of life. At a first level of impact, ART that reduces viral loads can provide tremendous benefits. Whereas medications provide clinical relief, aspects of the social contexts of women's lives that make them vulnerable to HIV in the first place may not necessarily change. For example, women may still be forced to forego schooling in favor of early marriages, their agency in sexual decisions might be diminished by social norms that increase male sexual privilege, they might be subject to stigma and discrimination as persons living with HIV, and they may also suffer from intimate partner violence (IPV) that creates trauma and intimidation. Further, were ART to be withdrawn, health benefits might disappear while the social circumstances remain.

Using intentional strategies, an HIV researcher can provide ART but also transform the research operation to synergistically improve the social conditions women face. There are several ways in which this can be done. In addition to providing and studying the effects of ART, researchers might also (1) work with local women's rights groups to provide community-based education on cultural and gender norms that place women at a greater risk for HIV compared with men, (2) offer educational incentives to women and girls in participant families to increase education and literacy, (3) promote the use of female condoms to increase women's capacity to protect themselves, (4) examine the effects of ART on subgroups, such as the poor, disabled, old, or rural, to understand life span effects and advocate for treatment for underprivileged women, (5) provide legal or advocacy services to deal with family violence or abuse, and (6) hire women to be the faces of the operation in the local setting, raising their status as leaders of the research. Women employees should be paid well, at least as much as men, and occupy key roles. Thus, the research initiative itself becomes an exemplar of equity in labor practices, possibly opening opportunities for women elsewhere.

In acting along these lines, health research intentionally enters the fray of women's human rights reform. It does so boldly with the backing of global, regional, and country obligations to illuminate and dismantle discriminatory cultural and social practices that affect women's sexual health. The research initiative is overtly working from a human rights framework, declaring the protection of women's dignity and fundamental freedoms as clear objectives. We outline six specific strategies to stimulate such second level of impact in health research, as suggested by Scale of Change theory, to move a study beyond individualized elements of health.

### A Human Rights Study Framework

Figure 1 outlines six strategies to deepen a study's social impact, and Table 1 lists Internet resources for additional information on each element. Conceptual and logistical pitfalls that accompany the use of these strategies are briefly provided, with recommendations for circumventing them.

#### *Strategy 1: Become familiar with women's human rights directives to incorporate them into the research*

Health researchers are generally unfamiliar with global and regional commitments to which nations are morally and

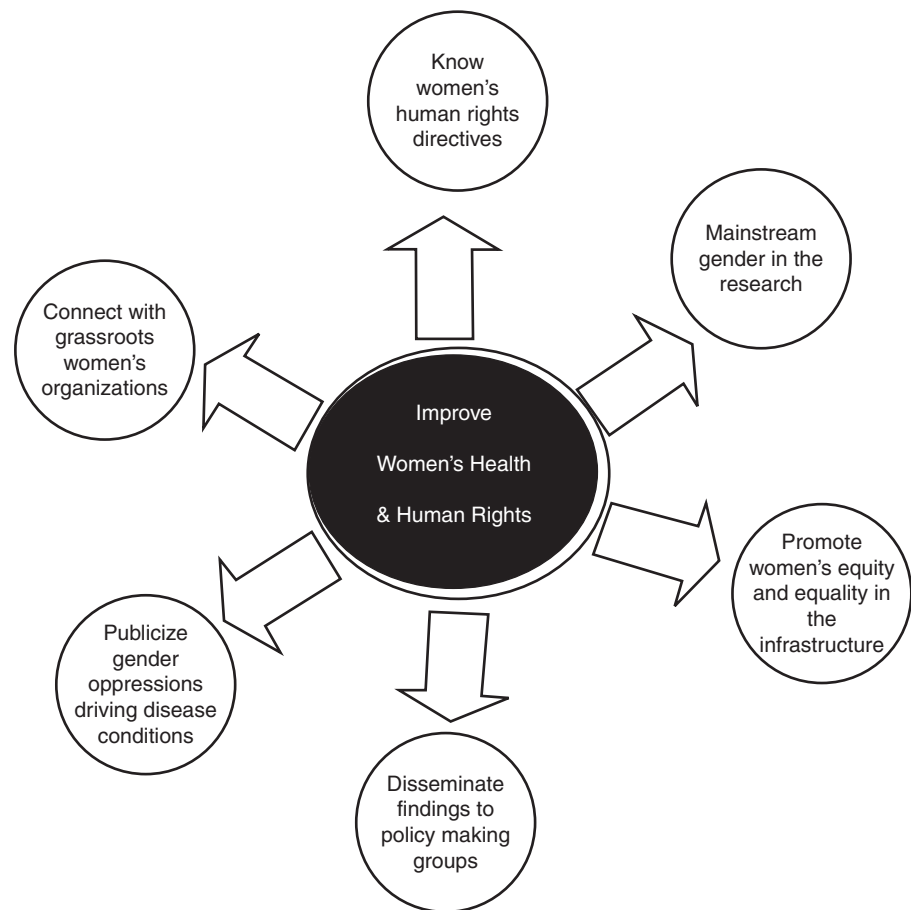
ethically bound in protecting the rights and freedoms of women.<sup>17-19</sup> Knowledge of even basic mandates (e.g., Universal Declaration of Human Rights<sup>10</sup> and the CEDAW<sup>11</sup>) can provide frameworks, nomenclature, and strategies for planning health research. These documents can stimulate an intellectual appreciation of the need to improve women's overall standing while addressing health conditions. The Internet offers many academic and technical reports that are readily available for self-education on women's human rights mandates, and Table 1 (Strategy 1) shows a link to an extensive women's human rights resource database. The database offers a compendium of annotated reports, articles, and links specifically on country, regional, and global women's rights commitments that can be searched by subject area, authorship, or other aspects.

Researchers may encounter resistance from country or local officials on some aspects of rights for women, especially where paternalistic norms and practices are at odds with promotion of some health practices (e.g., reproductive rights). Background information on country-level commitments and government endorsements of women rights charters and international conventions can add moral and ethical weight to positions that researchers take. For example, if a country embraces the Universal Declaration of Human Rights<sup>10</sup> and the CEDAW,<sup>11</sup> researchers can also adopt these documents as the moral and policy framework guiding the research. Researchers can then sensitively and respectfully invoke the language of these charters to frame their research aims and mission while also remaining committed to a sustained dialogue with local gatekeepers about different viewpoints on specific elements of women's rights.<sup>9</sup> Whereas country officials and national women's groups may be fully acquainted with international or country human rights mandates (e.g., CEDAW) at the grass roots level, local gatekeepers may be unaware of such commitments; therefore, sensitivity and a commitment to dialogue and finding common ground are key.

Communicating deep interest in serving women is certain to resonate with some person or group in a setting that can be foundational to building alliances in spite of differing viewpoints on rights for women *per se*. Indeed, many local organizations (e.g., faith-based groups) may push back against the idea of some rights (e.g., therapeutic abortions), yet in other areas, they may be significant allies in providing organic supports for women that are key to their everyday survival and overall health (e.g., health clinics).

#### *Strategy 2: Mainstream gender in the research*

Gender mainstreaming refers to "making women's as well as men's concerns and experiences an integral dimension of... design, implementation, monitoring and evaluation so that women and men benefit equally."<sup>20</sup> It was formally adopted by the Beijing World Conference on Women as a strategy to improve equality of women in many spheres, including health.<sup>9,21-23</sup> A detailed discussion of gender mainstreaming is outside the scope of this article. In Table 1 (Strategy 2) we provide links for further reading on gender mainstreaming strategies (eg., gender auditing methodology and sex and gender-based analyses in health research). Briefly, two practical principles to mainstream gender in research are (1) to prioritize the collection, disaggregation, and analysis of data by sex, age, and socioeconomic status to



**FIG. 1.** Strategies for a women's human rights framework in health research.

illuminate studies' effects on women as well as men<sup>21-23</sup> and (2) to introduce a gendered view of the health condition under investigation to all staff and make it a core value in every aspect of the research.<sup>24</sup>

Lead investigators must themselves embrace a gendered view of health. With such an appreciation, study hypotheses must include sex and gender as key variables from the onset vs. later as add-ons. On this issue, WHO is clear:

If health... systems are to respond adequately to problems caused by gender inequality, it is not enough to simply "add in" a gender component late in a... project's development. Research, interventions, health system reforms, health education, health outreach, and health policies... must consider gender from the beginning.<sup>25</sup>

Thus, study hypotheses, data collection, and gender- and sex-based analyses must specifically illuminate the incidence and prevalence of women's diseases or responses to treatments because these data directly and indirectly affect the nature and quality of services women receive.<sup>21</sup>

### *Strategy 3: Tap the expertise of local grass roots women's rights reformists*

Worldwide, grass roots women's advocacy groups provide leadership, vision, and urgency to addressing social conditions affecting local women and their families.<sup>26</sup> For example, Mano River Women's Peace Network<sup>27</sup> (MARWOPNET), a grass roots women's group in Sierra Leone, Liberia, and Guinea, attempts to decrease civil conflicts in which women

are highly vulnerable to injuries and maltreatments. Likewise, *Colectiva Mujer y Salud* (Women and Health Collective),<sup>27</sup> a coalition of women's organizations in the Dominican Republic, lobbies the government to push back against prevention of therapeutic abortions for women. Local women's advocacy groups such as these can become consultants to women's health research, providing information on specific and even hidden cultural practices that violate women; local situations and conditions of safety and harm for women, and local and national governmental policies or cultural and religious practices that work for or against women's health. Most importantly, grass roots groups can also assist in empowering local women to advocate on their own behalf, and they can also serve as mediators in conversations with local gatekeepers who might be suspicious of opportunities afforded by the research. Grass roots women's movements might also create natural diffusion pathways for new knowledge about useful health strategies.<sup>26-28</sup>

Researchers may need to work creatively to find local grass roots women's groups in a setting, for example, through national and local phone books, community development projects, gender or women's studies departments of local colleges, or word-of-mouth. Philanthropic or funding organizations that target grass roots women's empowerment often provide grants and awards to such organizations, and their rosters can be scrutinized for names and contact persons. In Table 1 (Strategy 3), we list three organizations, Vital Voices<sup>29</sup> sponsored by Secretaries of State Hillary Rodham Clinton and Madeleine Albright, the Global Fund for Women (GFW),<sup>30</sup> and

TABLE 1. RESOURCES FOR ADDITIONAL INFORMATION ON RECOMMENDED STRATEGIES

## Strategy 1: Women's human rights information

A compendium of links to websites, articles and other documents on Women's Human rights  
[www.law-lib.utoronto.ca/Diana/whrr/index.cfm?sister=utl&CFID=1818617&CFTOKEN=87595324](http://www.law-lib.utoronto.ca/Diana/whrr/index.cfm?sister=utl&CFID=1818617&CFTOKEN=87595324)

## Strategy 2: Gender mainstreaming

Strategies for mainstreaming gender  
[www.capacitydevelopment.net/documents/ElementsGM.pdf](http://www.capacitydevelopment.net/documents/ElementsGM.pdf)

Gender audit methods  
[www.brookings.edu/papers/2005/05globaleconomics\\_moser.aspx](http://www.brookings.edu/papers/2005/05globaleconomics_moser.aspx)

Sex and gender analysis  
[www.cihr-irsc.gc.ca/e/32019.html](http://www.cihr-irsc.gc.ca/e/32019.html)

## Strategy 3: Grass roots women's groups (selected rosters)

Vital Voices  
[vitalvoices.org/](http://vitalvoices.org/)  
 Association for Women's Rights in Development  
[www.awid.org/](http://www.awid.org/)

Global Fund for Women (annual reports)  
[www.globalfundforwomen.org/cms/publications/reports/](http://www.globalfundforwomen.org/cms/publications/reports/)

## Strategy 4: Gender equitable organizational frameworks

Gender sensitivity training  
[www.konsnet.dk/Default.aspx?ID=18173](http://www.konsnet.dk/Default.aspx?ID=18173)  
 Better practices in gender sensitivity  
[www.prime2.org/prime2/pdf/9-11\\_BP\\_GSA\\_Tools\\_Web.pdf](http://www.prime2.org/prime2/pdf/9-11_BP_GSA_Tools_Web.pdf)

## Strategy 5: Dissemination to policy groups

Strategies for disseminating research findings  
[www.researchtoolkit.org/primer/docs/CARE%20Research%20Dissemination%20Guide.pdf](http://www.researchtoolkit.org/primer/docs/CARE%20Research%20Dissemination%20Guide.pdf)

Bridging gaps between health research and health policy  
[www.longwoods.com/content/17568](http://www.longwoods.com/content/17568)

Lawrence R. Research dissemination: Actively bringing the research and policy worlds together." Evidence Policy 2006; 2:373–384.

## Strategy 6: Publicizing health and human rights challenges of women

WHO health and human rights resources  
[www.who.int/hhr/HHRETH\\_activities.pdf](http://www.who.int/hhr/HHRETH_activities.pdf)

WHO, World Health Organization.

the Association for Women's Rights in Development, that can be searched for localized women's groups across the globe.

**Strategy 4: Showcase women's equity and equality in the organizational infrastructure**

Gender equity (fair and impartial policies) and gender equality (absence of discrimination) should be visible in the research infrastructure.<sup>16,22</sup> Often, a research operation may include mostly men, who may be viewed as more attractive employees because of greater mobility and fewer domestic responsibilities.<sup>24</sup> Thus, a gender gap develops in leadership, decision making, and representation of the research to external audiences, with males blatantly or subtly commanding a greater share of its resources, such as salary, leadership positions, incentives, and training. To advance women's equality and equity, researchers must alter male-dominated organizational templates<sup>24</sup> by recruiting women into leadership positions in the organizations, creating hospitable work environments for women, facilitating women's capacity for research decision making through training, offering accommodation for reproductive and maternal roles, making the workplace safe, and promoting women in dissemination roles.<sup>24</sup> Additionally, women voices must be heard in the organization through providing them with space to organize and to question gender-equality policies. Women can also take advantage of external opportunities (e.g., conferences) for greater education on gender equity and social justice.<sup>24,31</sup> Along these

lines, in Table 1 (Strategy 4), we provide links to gender sensitivity training and also gender-sensitive better practices.

Ensuring gender equality can take time and requires a declarative stance for equitable practices on behalf of women, even in settings where male privilege is the *status quo*. This may put a research operation at odds with prevailing norms of a community or country because, in practice, it might represent a cultural shift from such norms.<sup>24,31</sup> If researchers are serious about women's equality in an operation, however, structural adjustments are needed to alter exclusionary practices. For example, scientific elements must be gender sensitive,<sup>19</sup> such as getting informed consent from women even in settings where others traditionally speak for them, planning procedures with accommodations for women's care-giving responsibilities (e.g., home visits; child care), ensuring women's safety at and mobility to study sites, and using gender-sensitive language in surveys and other measures.<sup>19</sup>

**Strategy 5: Disseminate findings to policymakers to advocate for improved services**

Health policymakers, such as government officials, country offices of international organizations, pharmaceutical industries, and health consultants, need research findings on women's diseases to plan health resources.<sup>32</sup> A grasp of women's responses to specific treatments can have significant ramifications on how health resources are prioritized and what recommendations are provided to clinicians.<sup>21</sup> For

example, lack of information on women's responses to specific medications can cause confusion about dosages, side effects, and effectiveness of drugs in women. Harris et al.<sup>33</sup> document sex differences in drug metabolism and adverse reactions to drugs because of pregnancy, menopause, oral contraceptives, and menstruation. Coronary heart disease (CHD) is another good example.<sup>17,21</sup> As recently as 2003, global CHD research barely included sex and gender analyses; thus, understated hypotheses, inadequate data on CHD pharmacology, and behavioral regimens ultimately cause inadequate knowledge among clinicians treating CHD in women.<sup>17</sup> To improve overall health conditions for women, researchers should develop sex- and gender-based profiles in studies (Strategy 1 on mainstreaming gender) and disseminate such information to influence local health policy. In Table 1 (Strategy 5), we provide links to documents that discuss dissemination strategies to varied audiences and also tips on bridging health research and health policy gaps.

Increasingly, funding agencies are requiring researchers to include women or to justify their exclusion in health studies, and these steps are compatible with women's human rights. Researchers may cite financial and logistical barriers to recruiting meaningful numbers of women into research or resist making accommodations for their involvement or push back against a requirement of sex and gender analyses of study effects. Such resistances are contributing to a dearth of research data on women globally and to an inadequate understanding of the gendered nature of diseases worldwide.<sup>19,21</sup> Additionally, researchers may present study findings to only narrow scientific communities (e.g., disciplinary conferences, scholarly journals), missing opportunities to educate local health officials, women's rights organizations, and other grass roots groups on strategies that can save women's lives.

#### *Strategy 6: Publicize specific and global oppressions driving women's illnesses*

The CEDAW<sup>2,19</sup> and other women's rights directives suggest that researchers have an ethical and moral responsibility to illuminate gender discriminations along with scientific elements of the research. Gender discriminations can be creatively embedded in public presentations in which researchers share two storylines: (1) scientific paradigms of the health condition under investigation and (2) the specific and global discriminations that women face that make them vulnerable to the health condition itself. For example, Third World Network<sup>34</sup> documents current health circumstances of Haitian women after the recent earthquake. Displaced women face a double jeopardy of amputations and respiratory diseases and also sexual violence and a future prognosis of poverty because of decreased labor opportunities.<sup>35</sup> Thus, in Haiti, health conditions and social conditions of women are intertwined. Similarly, an account of maternal and child health in the Gaza Strip during the 22-day Israeli-Palestinian war, points to women's delivery of babies in cramped and unsafe quarters or on the run from the violence, with maternal bleeding, premature birth, and death being some of the outcomes.<sup>36</sup> We recommend that researchers present health accounts and social conditions of women together, highlighting the intersecting storylines. In Table 1 (Strategy 6) is a link to WHO documents linking health and human rights associations among a list of diseases conditions.

Scientific fields often place greater emphasis on diagnosis and treatment of diseases than on the social conditions that explain the presence or absence of diseases, and we are recommending a departure from this mold.<sup>2,9</sup> Unidimensional storylines focused only on diagnoses and treatments present women's health conditions through a narrow lens that should be widened to illuminate the indelible linkage between women's symptoms and their social standing.<sup>2,9</sup> In the next section, we illustrate how one research study successfully achieves this objective by using a human rights framework in obstetric fistula research. This study intentionally incorporates the six strategies we recommend.

#### **Case Study: Obstetric Fistula Reduction and Women's Human Rights in Nigeria**

Nigeria, with 144 million people, is the most populous country in Africa, with estimates of up to 1 million women suffering from obstetric fistula.<sup>37</sup> A fistula develops in a woman when the blood supply to the tissues of the vagina and the bladder (or rectum) is cut off during prolonged obstructed labor. The tissues die, and a hole forms through which urine or feces pass uncontrollably.<sup>4</sup> The physical and social consequences of fistula are devastating and include incontinence, infections, and vaginal ulcers, as well as divorce, social estrangement, and psychological trauma.

Gender discrimination is a major factor contributing to the prevalence of fistula in Nigerian women. Fistula incidence has been empirically associated with early childbearing in child marriages and with rape, in which underdeveloped reproductive organs of young women heighten their experience of birthing traumas, leading to high maternal and infant mortality rates. Inadequate care during deliveries (e.g., no skilled attendant) as well as traditional practices (e.g., genital mutilation)<sup>37,38</sup> also are predictors of fistula. Women's inability to space out the births of their children because of lack of family planning options or because of partner dictates can also lead to fistula. Low educational levels and lack of spousal permission also prevent women from obtaining the relatively simple surgical procedure for fistula repair.<sup>37,38</sup>

To decrease the prevalence of fistula in Northern Nigeria, the Population Media Center (PMC)<sup>38</sup> conducted a study aimed at increasing women's awareness of and access to surgical procedures for fistula repair as well as family planning services and products in free clinics supported by Rotary International. PMC is a nongovernmental organization that uses research-based entertainment education strategies in developing countries. Their fistula study targeted physical health aspects (e.g., knowledge of and access to surgical options) and cultural and social norms (e.g., early marriage and childbirth) and maltreatment (e.g., social ostracism) that make young women vulnerable to developing this condition.<sup>38</sup> PMC's study was funded by the Rotarian Action Group on Population and Development (RFPD), the David and Lucile Packard Foundation, and the Conservation, Food and Health Foundation.

PMC's primary intervention to decrease fistula and also address the social conditions influencing it was a 70-episode research-based radio serial drama called *Gugar Goge* (Tell It To Me Straight). *Gugar Goge* was broadcast over regional government-owned and private radio stations in Kaduna and

Kano states from June 2006 to February 2007. Listenership data showed that around 91.9% of the population in Kano and Kaduna states had heard at least one episode of the program, and around 82.1% of those interviewed reported listening to an episode at least weekly (four or more episodes per month).<sup>37,38</sup>

*Gugar Goge* depicted the life of a 12-year-old girl who developed fistula because of obstructed labor. In the drama, the girl obtained surgical treatment for her condition and continued life as a successful seamstress. Thus, *Gugar Goge* shows how simple access to fistula surgery can improve quality of life. The drama encouraged women to access fistula treatment centers and to obtain family planning services through free clinics operated by Rotary clubs. At a first-impact level (suggested by Scale of Change theory), *Gugar Goge* increased knowledge about fistula and the use of fistula surgeries among listeners compared with nonlisteners. The number of women accessing healthcare services in the five clinics in the broadcast area dramatically increased. Data collected midway through the 70 episodes showed that 33% of the new clients seeking reproductive health services and 54% of the clients seeking fistula services were motivated to seek healthcare services because they listened to *Gugar Goge*.<sup>37,38</sup> When asked if a condom was used the last time they had sexual intercourse with a man, 79.5% of female listeners to *Gugar Goge* said "Yes" compared with 35.6% of female nonlisteners.

*Gugar Goge* also has a second-level impact by altering elements of the social reality of men's and women's lives. The drama realistically and boldly tackled gender discrimination through story lines that presented child marriage, women's need for permission from their husbands to obtain health

services, women's lack of reproductive choices in determining the spacing of children, low-quality health services received by women, and their lack of education and health literacy as the reasons that kept women unaware of the relative simplicity of fistula correction.<sup>37,38</sup> Sexual discrimination, such as male infidelity, that placed women at greater risk to contract HIV and other diseases was also highlighted. By having characters in the drama experience and seek to resolve these situations, *Gugar Goge* brought to light Nigerian gender and cultural norms and stimulated active conversations among all levels of listeners about violations of Nigerian women's sexual and reproductive rights. *Gugar Goge* significantly improved male listeners' knowledge and attitudes toward fistula. For example, when asked their opinion about whether "a woman with fistula should be part of the community like everyone else," more male listeners (32.1%) strongly agreed with the statement than did male nonlisteners (17.6%).<sup>37,38</sup> In focus groups, participants were asked to describe the impact of *Gugar Goge* in their lives. One 20-year-old male respondent stated:

Prior to listening to *Gugar Goge*, I did not know much about women's reproductive health issues. But after listening to the program, I feel enlightened . . . After learning from *Gugar Goge*, I told my parents not to marry off my two younger sisters early. I have two younger sisters, 12 and 8 years old. I have seven older sisters who have all been married. Some were only 13 or 14 years old. They have faced many problems. My parents have accepted my advice. At least my two younger sisters will be saved.<sup>37</sup>

As a result of PMC's studies and soap operas, such as *Gugar Goge*, local officials and women's rights groups are energized

TABLE 2. POPULATION MEDIA CENTER'S WOMEN'S HUMAN RIGHTS FRAMEWORK IN FISTULA RESEARCH

<i>Women's human rights strategy</i>	<i>Example in PMC's fistula research</i>
Become familiar with women's human rights directives	Global regional and country documents relevant to women's rights in Nigeria were used to develop a written moral and policy framework and values grid for <i>Gugar Goge</i> that was then used in creative training and scriptwriting
Mainstream gender	PMC collects and analyzes data strictly by sex and gender (e.g., male and female listenership, perceptions of acceptance of fistula, family planning behavior and attitudes); key demographic indicators, such as family income, urbanicity, and disability, are also collected; surveys are collected in woman-friendly settings and households
Attend to women's equity and equality in the organization	Nigerian women make up around 50% of the creative team scripting and producing dramas; women serve on technical and creative advisory groups and also as research assistants; trainers on fistula access to services are also mostly women
Connect with grass roots women's organizations	An organization of Muslim women served as consultants on the steering committee that approved pilot episodes and as technical experts on storylines
Disseminate to policy organizations	PMC conducts an official research findings ceremony to inform local health officials from health departments/ministries of health; donor organizations and country international organizations offices (e.g., UNFPA and UNICEF) are also invited
Educate on gender oppressions driving diseases	Two broad storylines in <i>Gugar Goge</i> related to getting help for fistula and accessing family planning services in Rotary clinics; social and cultural norms driving up the incidence of fistula (e.g., male sexual privilege, child marriage) were also depicted

to enact policies preventing child marriage and providing women access to family planning services.<sup>38</sup> In Table 2 we highlight specific strategies consistent with our recommendations that PMC used to improve the study's human rights elements in its bid to reduce fistula prevalence and increase family planning services.<sup>37,38</sup>

## Conclusions

Our main premise is that health research may increase treatment options for women by providing clinically sophisticated procedures, new medication therapies, or innovative prevention approaches. Although such improvements are beneficial, however, they scarcely address alterable social conditions that violate women's right to freedom, equity, and equality.<sup>2,4</sup> Further, social disadvantages and oppressions are taking a huge toll on women's health worldwide. Global, regional, and country commitments suggest that civil society, including health researchers, is obligated to regard women's human rights as an ethical and moral responsibility.<sup>11–13</sup> This is also our stance. Intentional use of Scale of Change theory and practice strategies that may not necessarily require additional resources can deepen the social impact of studies and challenge social conditions for women.<sup>5–8</sup> Our recommendations relate to transforming the research environment itself, such as taking a gendered view of health and promoting gender equity and equality in the infrastructure.<sup>16</sup> Other strategies require researchers to publicly declare a position on women's empowerment and advancement, even in countries and communities where this may be at odds with the *status quo*. Researchers' personal paradigms (e.g., conservative abortion views) and scientific transitions and norms (e.g., where study findings are disseminated) may be barriers to valuing women's human rights. However, we must find urgent solutions to women's health concerns for development and progress, and that includes attention to how their countries, communities, and families treat them.

## Disclosure Statement

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