From social inequalities to cultural differences: gender, "race" and ethnicity in sexual and reproductive health in Colombia

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Sexuality, culture and politics
A South American reader

Although mature and vibrant, Latin American scholarship on sexuality still remains largely invisible to a global readership. In this collection of articles translated from Portuguese and Spanish, South American scholars explore the values, practices, knowledge, moralities and politics of sexuality in a variety of local contexts. While conventionally read as an intellectual legacy of Modernity, Latin American social thinking and research has in fact brought singular forms of engagement with, and new ways of looking at, political processes. Contributors to this reader have produced fresh and situated understandings of the relations between gender, sexuality, culture and society across the region. Topics in this volume include sexual politics and rights, sexual identities and communities, eroticism, pornography and sexual consumerism, sexual health and well-being, intersectional approaches to sexual cultures and behavior, sexual knowledge, and sexuality research methodologies in Latin America.

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Introduction

In this article we reflect on transformations currently taking place in the field of Sexual and Reproductive Health (hereafter "SRH").[1] We will focus on the use of *gender* and *ethnicity* as analytical categories within institutions providing SRH services. This is offered as a contribution to the reflection on medical knowledge, bio-politics and sexuality. SRH discourse, at the crossroads of medical anthropology, gender theory and new theoretical developments in the field of sexuality,[2] is one main source of authority and legitimacy for contemporary definitions of what sexuality is and should be. This discourse is closely related to public health interventions and the promotion of new sexual attitudes and behaviors.

Gender and ethnicity were not chosen by chance to speak about the implementation of SRH policies in institutions where this kind of services is provided. Both categories have been articulated by international and local government agencies for the design of public policy and applied programmes. Although the inclusion of these categories represents an important achievement, it is necessary to reflect on how they have been adopted and on the actual effects of their articulation. While both categories have been included in the aforementioned programmes, they have been articulated in diverse ways and as a consequence of equally diverse historical processes. For instance, gender influenced the very origin of the concept of SRH, as related result of feminist lobbying at international agencies (Viveros, 2003), but the concept of ethnicity has only recently been incorporated into debates on SRH, and reflects the

[1] Based on our research project "Qualitative evaluation of sexual and reproductive health programs on youth: gender, class, skin color and sexual orientation," carried out at the Center for Social Studies, National University of Colombia, with support from the Ford Foundation.

[2] Such multiple origins constitute both a strength and a weakness, given the difficulty to articulate the internal problems and dynamics of each of those fields.

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privileged position allotted to cultural difference in the current context of globalization and multiculturalism (Cf. Kymlicka, 1995; Taylor, 1992).

Taking this into account, we want to understand how and in which conditions these categories are transformed and adapted under the influence of the institutionalization of SRH. This transformation and adaptation can become evident in different ways, either by visualising new social problems, as a practical, sometimes simplifying, application of theoretical categories, or as a mere rhetorical exercise. We also have to bear in mind the different lines along which this institutionalization takes place: from social movements to academia, from academia to funding agencies, from the funding agencies to academia, from social movements to funding agencies, and from them to the programmes, etc.

The institutionalization of Sexual and Reproductive Health

The concept of SRH is closely tied to the feminist movement of the 1960s and 1970s, which uncovered the political character of sexuality and reproduction. In the area of health services, feminist struggles expressed the demand to universal access to contraception and abortion, both linked to women's claim to dispose of their own bodies. A defiant stance over these disputes brought forward the gender perspective on health socially and politically, bringing these issues from the private into the public realm, and making the body a site of political struggle. This motivated international organizations such as the World Health Organization by the end of the 1980s to take interest in health problems related to reproduction and sexuality issues (Scavone, 1999; Viveros, 2003) .

The coinage of the concept of SRH followed from negotiations between feminist non-governmental and international agencies. Since the beginning of preparatory debates for the International Conference on Population and Development (Cairo, 1994) contradictions between the implicit bases of population and demographic control and the ideals of autonomy and liberty expressed in feminist claims became quite clear (Scavone, 1999). One of the most important results of those negotiations was the institutionalization of the concept, with various effects. On the one hand, the problems of reproductive health received public attention and the object of a greater engagement by non-governmental organizations, therefore becoming visible and better known among the general public. On the other hand, the investment of feminist women on the subject received international recognition and, for the first time, alliances between feminist, non-governmental organizations and international agencies became possible.

While for the most part in southern countries the concept of SRH was adopted in response to authoritarian politics of demographic control, it did not eliminate the political risk of imposing reproductive models that are alien to women's interests, particularly among dominated ethnic and racial groups. The institutionalization of the concept of SRH by international agencies and family planning associations unexpectedly introduced

of a new rhetoric and vocabulary to the traditional subject of population control and old demographic politics and practices.

In the course of developing the concept of SRH, new perspectives on issues of reproduction emerged, breaking with the exclusivity of bio-determinist explications. These introduced a regard for autonomy and liberty among the subjects involved in reproductive events. In short, subjective, political, economic, social and cultural aspects emerged which up to then had been hidden by the medical approach to reproduction. This concept became a tool to argue that anatomy need not women's fate any longer (Beauvoir, 1989), nor was maternity a biological fatality. Issues of reproduction were to be understood as the result of gender relations.

Gender in Sexual and Reproductive Health

The role assigned to gender relations in SRH as a critique of the association between women and reproduction, with its negative consequences on women's health and their rol in the family, did not maintain its initial strength.

Despite the fact that the gender perspective was one of the most recurrently mentioned issues in SRH policies and programmes, there was no agreement about its meaning. Sometimes gender is used as a socio-demographic variable, instead of a crosscutting concept in social relations. The concept is often used to refer to a list of differences between men and women, to generate differential attention for each group. A less common use is to conceive gender as an element of hierarchical order. This latter approach would put more emphasis on sexual and reproductive rights and generate actions that transform hierarchies and their effects on medical practices, the ways populations are characterized, and how sexuality, prevention and risk are being thought. Gender constructions determine attitudes and behaviours that involve specific morbidity and mortality risks, as well as differences in the use and access to SRH services.

On a macro-social scale, the sexual division of labour in institutions impacts the way family and social funds necessary to maintain SRH are assigned on the individual level according to the sex, as well as on the differential access to health services and social security. Furthermore, medical discourse and reproductive technologies have harmfully prioritized interventions on women's bodies, assigning techno-medical practices a central role in the reproduction of masculine domination (Viveros, 2003).

Regardless whether the category of gender is pertinent for a given population, it should be conceived as a relational category, as it initially was. Service providers and practitioners (medical practitioners, nurses, psychologists, social workers, etc.) are also gendered subjects, affected by gender prejudice, conceptions and attitudes. Although in certain programmes the hierarchical effects of gender on the social context

of the affected subjects is being criticised, the operation of this category operates in the working sphere of these programmes, i.e. in career paths, daily treatment, the ways women are required to present themselves, etc., is seldom considered.

In short, a rigorous assumption of a gender perspective implies understanding its repercussion on social inequalities and committing to the transformation of the practices that enforce and reproduce old or new models of domination.

Ethnicity and "race" in Sexual and Reproductive Health

Before addressing the inclusion of ethnicity and "race" in SRH, a few precisions should be made. First, it should be recognized that ethnicity defines gender relations and places them on a broader social dynamic. Second, there are common elements in the ways these two categories work, in particular because natural, sexual and phenotypical features have been used as sources to explain social relations of dominance, power and exploitation based on gender and ethnicity. Finally, the social and constructed character of categories of gender and ethnicity does not acquit them of material effects.

We can hold that inclusion of ethnicity in the debates about SRH is associated to the feminist denunciation of social inequalities between countries of the Northern and the Southern Hemispheres; to the increased difficulties experienced by women who are the object of ethnic categorization in the Southern Hemisphere, and to access to reproductive health services and reliable information on contraception. Furthermore, such inclusion is related to the identification of cultural differences as obstacles to implementing health programmes.

Regarding today's multicultural and at the same time racialised framework of ethnic relations, as product of Latin America's colonial history, one should note that the notion of "ethnicity" has often replaced that of "race". Such substitution is related to the assumption that the term "race" perpetuates racism, or to the fact that its history is seen as politically incorrect (Wade, 1993). Despite the importance of maintaining a distinction between "race" and ethnicity, it is also necessary to point out that racial and ethnic identification overlap both analytically as in practice. Both refer to the transmission of features through generations, to phenotypical aspects and location in a cultural geography (Wade, 1993).

At least three direct links between SRH, ethnicity, and "race," can be tracked in Latin-American history. The first refers to health conditions in the strict sense of the term, and the remarkable inequalities identified in quality of life indexes of the black and indigenous populations with respect to the rest of national populations. The second refers to the relationship between therapeutical knowledge among the different ethnic groups, on the one hand, and Modern European medical knowledge on the other. The

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third alludes to the relation medical institutions maintain with the groups subject to ethnic categorization. These three links show that ethnicity and "race" incorporate elements such as social capital, geographic location, beliefs, traditions, and the exercise of civil rights that impinge on each social group's access to sexual and reproductive well-being or their chances to fall ill (Viveros, 2003).

From the time of colonization and throughout the colonial period, the reproduction and health conditions of the indigenous and enslaved black peoples were seriously affected. They were the victims of epidemics introduced by Europeans—to which they their immune systems were defenceless—, and of severe living and working conditions. This led to an important demographic decline and a series of stigmatization processes. The features of the Amerindian and African populations and their descent were constructed as the negative of those supposedly characterizing the Spanish *conquistadores.* That stigma caused severe representational effects which are very much present today: the former peoples have been represented as lazy, savage, superstitious, libidinous, and unable to overcome poverty. Independence and the emergence of new nation states did not bring much change to the living conditions and social position of these groups. The multicultural and pluri-ethnic realities of Latin-American nations continued to be, for many years, subject to homogenizing social policies and programmes (including matters of of health), lead by a civilizing will, intended to "redeem" the people from those ills (Bonfil, 1989).

It was only since the mid-20th Century the indigenous peoples, and more recently the social movements of Afro-Americans, started to claim-aside from their demands for land rights, linguistic and cultural recognition, and political autonomy-social rights including equal access to health services which should be available to all citizens. Moreover, the precarious professional insertion of indigenous peoples and Afro-Americans in the process of economic modernization did not allow them to benefit from health services provided by Social Security systems. In short, the stain of extreme economical, juridical and social marginalization, political and military domination, slavery and subjection of groups descending from indigenous and African ethnic groups did not vanish with the social reforms brought by independence and the ensuing processes of democratization—even less with capitalist economic development. On the contrary, the internationalization of the economy consolidated these groups' health deficit, conditions of inequality, and exclusion from access to information and health services, including SRH.

The contemporary recognition of the pertinence of an ethnic perspective (sometimes adopted unreflectively) motivates actions in medical care and health promotion. Those are often conducted adopting differentialist approach, missing the historic configuration of differences into inequalities. Hence difference is mainly addressed as a cultural obstacle, part of the "nature" of these "populations".

Finally, let us consider medical knowledge a cultural practice. Public health has also functioned as a normative system that in Latin America was associated to the vast undertaking that meant the acculturation of the indigenous and African populations. Likewise, programmes to fight major endemic diseases have always been associated to practices of inferiorization and subjugation of those populations, i.e. the constitution of specific political relations within which the European society exercised its power through the imposition of its medical knowledge and sanitary controls (Fassin, 2001).

Taking into account the imposition of a legitimate definition of divisions and visions of the social world is one way to explain why a majority of medical practitioners still maintains the view that among diverse indigenous and black groups subjected to racialisation, health conditions are the effect of problems related to "education" (understood as formal schooling). That is why certain approaches continue to rely on the assumption that the gender, sexual and reproductive relations of these groups are known beforehand, and why they are treated as phenomena without history.

Including differences in a nation-wide campaign

In this section is a case study of one nation-wide campaign by an SRH non-governmental organization (NGO) to promote condom use among women in Colombia. The campaigned targeted women in a variety of settings—urban, rural, indigenous, and black–and encouraged them to question prejudice regarding the women who use condoms. With a strong media component (television, radio, posters), the campaign is an example of how gender and ethno-racial differences have been addressed when marketing sexual and reproductive health services–particularly in the media—within the multicultural milieu currently dominant in the country. Two officials involved refer the campaign like this:

> The goal of the campaign is that all women, of all colours, all races and all ways of life say that they are ready to carry it [a condom] with them. (Interview with official # 5) The idea is that all of us women can carry a condom and that this does not mean that they are going to make a bad pass at us, or that we are forward. And that not only... ah... let's say... the black race, but **all women, black, *mestiza,* that all can say "I carry a condom"**. (Interview with official # 4, our emphasis)

The campaign included outreach work with rural women in Boyacá, indigenous Wayúu women and some women from the larger cities of the country. The posters show photos of different women. The first series featured a black woman (a professional model), and a well known young white-*mestiza* woman from a popular teen TV show. The posters for the second series were not yet available at the time this article went to press. What strikes as evident is that a health campaign of these characteristics can only be created in a context where cultural difference is proclaimed as a value in itself.

It should be stressed that this campaign and the whole work that organization has been developing are part of a very valuable investment on SRH in Colombia. They reflect an effort to use alternative languages and practices, and incorporate the multicultural framework derived from the constitutional process of 1991. Regardless its problems, it is an important achievement in the construction of inclusive citizenship.

The basic idea of reach out to all women *of all colours, forms and sizes,* besides expressing an intercultural meeting point, is a marketing and social intervention strategy. As a strategy, it incorporates a discourse on difference in order to install a series of uniform behaviours through a language that has been culturally adapted to diverse women. Its first goal is to achieve identification with the women in the images, but it shall be them, the women marked by difference, the ones who talk to their *peers.* The relatively widespread method of peer education in SRH interventions is applied. In synthesis, while the campaign's point of departure is the inclusion of diversity, in particular cultural diversity, its goal is to homogenize this diversity through a unique proposal, namely, carry a condom.

"A woman, just a woman"

Although to a lesser extent today, it is still surprising that the opening image of an advertising campaign shows a young black woman. The *mise-en-scène* is also novel, even more so for health campaigns in Colombia. Although the model is represented with an ethnic attribute (dreadlocks): she is placed in an unusual urban, modern setting, lacking typical attributes like drums, palm trees, sun, poverty, hunger, traditionally used to represent black people in Colombia.

When we asked officials why a black woman was chosen for the campaign, they highlighted that it was indifferent who they chose, since it was meant to represent Colombian women in general. Such indifference seems paradoxical, given that the goal of the campaign was to show different *types* of women—indigenous, rural, urban, and black—proclaiming the same message: "I carrying a condom". Thus, the selection of a black woman to express diversity, however difficult to explain, is not random. As Zenaida Osorio (2001) pointed out when writing about school manuals, the presence of black women in advertising is aimed at highlighting differences and, by the same token, equality.

One official made the following remark, regarding unanticipated associations propitiated by the campaign:

> When we started the campaign with the poster [...], one person [at the speaker's institution], a manager, said to me: 'it's all very well, because of the AIDS of the blacks [*porque el SIDA de los negros*], it's obvious, it's their thing, so let them have

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> it'. Well, one of our managers said that to me, so then we thought about it. It had never been our intention to link black women to AIDS, promiscuity to black women, or protection and black women, but she as a symbol for women. **It did not matter that she was black**. Moreover, when we chose the photo [...] we had, 12 women, more or less, 12 pictures of different women, and the photo was chosen by a focal group, one of those you have to make decisions about ad campaigns. It wasn't like "this is a charming woman, we like her, so let's have her'. We selected 12 photos, of 12 different women, and people liked it. (Interview with official # 5, our emphasis)

We stress that the campaign caused multiple reactions, due to the polysemic nature of ad campaigns. There is no single way to decode the messages and to read advertising discourses, for the story "seems" what the reader attributes to the poster. In other words, each viewer participates actively in the creation of the narration (May, 1997). Some reactions included, often coexisting in one same recipient:

- A positive assessment of the change in representation.
- Lack of identification. Some recipients did not feel addressed, given that there are not that many black women in Bogotá.
- Criticism of the campaign for being inadequate to male taste. Some recipients said that the message was not adequate for publicity, because the woman shown "*is not the type of woman men like*", as one interviewee claimes.
- Conformity with the content. According to one interviewee, "*it is among blacks that condom use has to be promoted, because they are the most affected by AIDS*".

One answer, quoted in full, is telling:

> *What does the poster provoke in you, what does it transmit?*
> It makes me think about difference, that we have to understand that we are different. But I think that people do not identify, because the *mulata* girl in a video [...] I've seen youths laughing their heads off [...] but they do not really identify, because the girl is a minority, her race is not the majority here in Bogotá. It makes me think that we should break a bit with the white race girl idea. (Interview with official # 6)

The answers show that, regardless the inclusiveness promoted by the campaign, the message is being interpreted under a racial logic. This means that despite the will to show a "woman, just a woman", the model's phenotype prompts certain stereotypes, prejudiced, stigmatizing associations. Opinions show the connections usually made in the field of health between black people and HIV-AIDS, or between black people and sexual promiscuity, as well as the dissociation between being black and being beautiful. Some even dared assign a place of origin to the model on the poster, guessing that she would come from the department of Chocó, thus identifying her as someone "who is not from here," with whom the targeted audience would not identify.

In short, although the publicity discourse under examination sees differences as value-free attributes, the interpretations and readings it provoked evidence that the differences have value-laden connotations, build on hierarchies, and are grounded on social inequalities.

Condom use: a women's issue?

What were the goals of the campaign?

We basically wanted to start a process with the women. Have them learn to make decisions themselves, to negotiate, and understand that the condom element, although it is for the use by males, because there is not condom for women, is also their decision. So let them carry it too, have it on the, without feeling ashamed, learn how to use it. (Interview with official # 5)

The campaign was mainly aimed at *empowering*[3] women to use the condom and, as one official said, "it is an aggressive campaign because it questions several prejudices about women carrying the condom". Reactions of SRH programme users can be grouped as follows, according to perceptions about its gender-related content: some young female users rated it positively, because it questions prejudices about women's sexuality (mainly passivity, lack of autonomy, and lack of initiative); to other young users it appeared aggressive and promoted promiscuity among women; a third group of young female users complained that the idea is not equitable because, as this is the only contraceptive method for men, "now women also have to carry it" (group interview # 2), adding another obligation for women in relation to contraception and health care.

The campaign's basic assumption is certainly important: to achieve the empowerment of women in sexuality and health related issues. However, the strategy proved weak at achieving this goal. Should men be the target of a campaign addressing the issue, to assume their role in SRH and to stop obstructing women's decision-making on contraception? It goes without saying how frequently women go behind their male partners' backs to insert a device or get surgery. In some way, the campaign perpetuates the obligatory roles assigned to women regarding education and health protection. Its weakness is that it continues to attribute to women a central role in contraceptive and reproductive decisions, playing down masculine participation in SRH. On the other hand, it should be noted that such decisions should only depend on the will of empowered women, but on the persistency of gender as a social structure that limits the exercise of their autonomy.

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[3] English in the original, as the Spanish equivalents do not cover the whole sense of the term originally coined within the feminist movement. It refers to political and pedagogical processes which aim at making persons traditionally in dominated positions exercise power, and generate claims (see León, 1997). (Authors' note)

It must also be stressed that the inclusion of men in SRH programmes does, *per se*, not indicate a gender perspective. In a certain way, men are already present in these programmes, as company to their partners during medical appointments or "taking them to planning". Their presence, though, has not been significant insofar as it has not contributed to achieve equality. The rise in men's use of SRH services (with women remaining the main users) does not constitute progress in itself either, as their main concern are problems of impotence or sexual performance. Their presence in SRH services does not indicate a greater involvement in practices aiming at the limitation of existing gender disparities in SRH issues, but is another proof of the perpetuation of gender roles in sexuality. A differentialist gender perspective is insufficient to counteract social inequalities produced by gender relations in the exercise of sexuality. While female access to health care and affirmative action in access to, and promotion of, SRH should be a fundamental issue in the public health agenda, it is necessary to promote real masculine participation in SRH programmes and activities.

Conclusion

Rather a comprehensive perspective on the use of gender and ethnicity categories by institutions offering SRH services, this article has explored the way in which these approaches have been incorporated into their practices and discourses.

In the first place, we have argued that the process of institutionalization of gender and SRH is an important achievement for the diffusion, knowledge and visibility of the main problems in the area, but not without certain risks. When they are mainstreamed, concepts may become oversimplified, and their political content neutralized. They may simply add to the political correctness required by international financing agencies, rather than lead to a serious reflection by the institutions offering the services.

Secondly, we have shown the pertinence of including an ethno-racial perspective into SRH programmes. We deem it necessary to make visible the social and the constructed character of ethnic categories, as well as their consequences for social relations of domination and power. Likewise, the social inequalities and stereotyped representations of sexuality they cause have to be analysed. It is fundamental to evaluate from this perspective the actions and theoretical and methodological frameworks at the background of interventions and the promotion of SRH in Colombia.

Third, we have shown how important it is to bear in mind the social context in which the categories of gender and ethnicity were introduced into the scope of SRH. This multiculturalist context introduces a particular way of understanding difference as a value in itself, and ignores the existing links between these differences and social inequalities. We additionally point out that the current exaltation of cultural difference has not protected certain groups against racialised practices which they are still subjected to.

Finally, we have examined the ambiguity which has characterized the treatment of gender and ethnic differences in the advertising approach to SRH services. Despite the valuable efforts by the institutions offering SRH services to broaden the working perspective in the intervention and promotion of health, the power of medical discourse on sexuality, and the prevalent market logic in health services, neutralizes many of those efforts and continues to permeate SRH practices in Colombia.

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