

Gender equality awareness and sensitiveness of health personnel and community¹

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Abstract

The aim of this study is to determine the level of gender awareness and sensitiveness among health personnel and gender discriminatory approach of public on using health services. In this research descriptive methods were used with the qualitative and quantitative research techniques together.

The research has two universes. First is the community living in the region of Kızılcahamam primary health care clinic and the second is health personnel working at hospital and primary health care clinic in Kızılcahamam. Data of the research was collected from a sample selected from the first population and a study group of the second population.

Semi-structured questionnaire form prepared in line with the literature knowledge, developed by the researcher, was applied on 362 people who constitute the research sample by face-to-face interviews between May 2008 and June 2008. In-depth interviews were applied to 27 health personnel who constitutes the study group of the research between June 2008 and July 2008.

In research both qualitative and quantitative methods were used. Quantitative data have been evaluated on computer by percentage and chisquare using SPSS programme. Qualitative data collected from the interviews and open-ended questions were evaluated by the content analysis which suits research purposes.

The result of the study: According to the data obtained both from the public and health personnel, gender discriminatory approaches were identified in utilization of health services and in delivery of the public service by health personnel. A large number of quantitative and qualitative data related to existence of gender-based discrimination and violence were achieved in research.

Keywords:Gender; Health; Woman; Equality; Sensitivity

Introduction

Women and men, two important actors of the social structure share every field of the life, although they have an unequal position in the use of rights and opportunities in an asymmetric structure which can be seen in almost all the communities. In the historical process, a structure which controls, suppresses, protects and cares for women and makes decisions on their behalf is seen in

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the effect of the patriarchal system in almost all the communities around the world with less or more similarities and differences.

“Gender” term that is used to describe the relationship between women and men, which has been socially or culturally structured, defined and based on the identities, statuses, roles and liabilities charged on either sex is a term related to how the community sees, perceives, thinks and expects to act like an individual independent from the biological differences. Gender is a socio-economical variable is used to analyze of the roles, liabilities, limitations, opportunities and needs of women and men in every dimension. In contrast to biological sex, gender difference is not an inherent feature and may be socially and culturally structured, gain meaning and change over time (UNCHR, 2005; Akın, 2005; Dökmen, 2004; United Nations, 2006; WHO, 2005a: 5; NSW, 2000).

The concept of gender is shaped in the cultural heritage of societies as an expression of femininity and masculinity and forms one of the important components of social structures without the contribution of the individual. This concept is a normative structure that has been shaped over centuries, affecting from the traditions, customs, religion, law and daily life of societies. Although the roles of women and men are shaped within the system of norms requiring adaptation to the society as to reflect the society in which they live, these roles may have different aspects between communities and even between sections of society.

Gender equality is stated as women and men being responsible for the same opportunities, rights and liabilities (UNFPA, 2006). In other words, gender equality is not to do discrimination based on the gender of individuals in use of the opportunities, allocation and utilization of the resources and access to and benefiting from the services (Akın, 2005; NSW, 2000).

Gender equity is justice and rightness to be dominant in distribution of the responsibilities and earnings between women and men. Different needs and strengths are recognized between women and men with this concept. It is adopted to define these differences and do what is necessary (Akın, 2005). The differences existing in individuals also give rise to differentiation of the needs and some services are a strong need for a person or group, while the other persons may not need for such services. This system of values has been kneaded with specific structures of societies in the historical process, producing several stereotype judgments for gender. While the roles of societal gender are perceived as the division of labor between the sexes, asymmetrical distribution in this division brings inequalities together.

Gender discrimination begins with basically the parents, close relatives and neighbors as well as every segment in society and individuals and organizations to approach different to girls than boys

from a young age. When girls get hurt, their crying is tolerated, but crying behavior is not acceptable for boys and tried to be suppressed. Boys are expected to play with toys such as cars, pistols and rifles, while girls are approved to play house (Acar, Ayata and Varoğlu, 1999, p.6). These orientations are directed to bring women in characteristics such as coherence, decency and dolicity and men in independence self-confidence and power, thus to prepare girls and boys as individuals who fit the expectations of society.

Discrimination behavior affects both genders in different ways. However, social position and gender roles of women and the prejudices of the society fuel the gender discrimination against women. Conscious actions such as strengthening the position of women, elimination the obstacles on the way to access to basic rights such as education and health and increasing their participation to the decision-making process are supported by public or private and local or international effort, although women still seem to be behind the position longed for.

Underlying causes of discrimination against women include under-representation of women in the fields of social institutions and work based on the traditional position created by the role of the gender supported by the education system, lack of education and a low social status as an indication of this. Social status of women has changed over time, although inequalities are observed to still continue in developed and developing countries. The struggle of women has taken place from past to present to be an individual with equal opportunities with men in society and behavior patterns those widely continue in many communities has been an obstacle to this effort. Women have been affected from this discrimination sometimes in form of their fundamental niche to be limited with house, and the problems resulted from being a woman and mother in the patriarchal family and sometimes in form of exposure to different forms of violence. Especially women living in traditional environments assess this situation as desperation, accept and see it as normal.

The problems, including women's situation, low social status, insufficiency in decision making and being represented, inadequate employment in income-generating jobs, additional health problems related to reproductive health, poverty and occasional image of dependency and helplessness are essentially educational problems. A woman is featured with her biological identity in almost every community and evaluated with limited features of the motherhood and being a good wife. This can pose obstacles to her active participation in social life.

High status of individuals is considered important in development of societies (KSGM, 2008b, p.9). Naturally, rise of the women's status will contribute to the development of society. Studies to improve equality between women and men are statistically evaluated and reported in Turkey, which approves the project and the efforts of the international organizations for improving the women's

status and takes place in these efforts. A widely and internationally recognized assessment of equality of opportunity between women and men is "Human Development Index." According to the Gender-Related Development Index created by comparing the values based on gender in terms of education, health and income criteria included in that index, Turkey ranks 112th by 98.5% out of 156 countries. According to data from UN Development Program, men seem favored over women in terms of adult literacy and combined enrollment ratio (KSGM, 2008a, p.9). Despite these efforts for strengthen the women's status with education are right steps, based on the indicators it is seemed that the position of women is still not high enough in the practice as desired.

Women being biologically different from men is one of the causes for them to have more different health problems. At the first glance, the differences between women and men are maternal health problems such as pregnancy and childbirth, problems emerging in the menopause period with the end of fertility, and the problems encountered in these natural processes. Except for the duties of motherhood, women have also different health problems caused by their biological structures. Low social status of women affects both their health levels and fertility and access to the health services. Gender roles and discrimination directly or indirectly affect the women's health. What to do in the long term are to rise and strengthen social status of women and to apply "equality and equity" principles between genders.

Status of women directly affects their health. Not benefiting from educational opportunities and woman poverty are the best-known types of discrimination and an obstacle to women's access to services. This weak position of women sometimes renders them unable to decide even for the medical procedures to be performed on their reproductive functions and bodies and to access to health services.

Inequality experienced in access to health services is one of the important factors affecting women's health. There are inequalities for women to access health services and primary health care resources delivered for prevention and treatment of childhood diseases, poor nutrition, anemia, diarrhea-related diseases, infectious diseases, malaria and other tropical diseases and tuberculosis. In the developing countries annually 35% of all the pregnant women, i.e. approximately 45 million women don't receive health control and care services. Women have a limited power and ineffective position in the decision-making process for their own sexual and reproductive lives. Female circumcision and other interventions for reproductive organs which are exposed by more than two million young girls per annum are among the inequalities which women may encounter (Ecevit, Y. 2003, p. 84).

Features and functions of reproduction in women make the women's health a very special field. The most outstanding result of social gender discrimination emerges from utilization of health care services, while low social status affects most the fertility behavior. An inequality between women and men related to reproductive health problems continues from birth to death against women. Burden due to reproductive health among the causes of disease burden in 15-44 age group is 3 folds greater in women than in men in the developing countries. In this group of age, one of each 5 diseases develops due to motherhood. Disease burden of sexually transmitted infections is also greater in women. Pregnancy and pregnancy-related deaths occur under the impact of economical status, social status and role of the women's and environmental conditions (Akın and Mihçioğur, 2003:127-139; Özvarış and Ertan, 2003:112-126).

One of the most common social causes of maternal mortality is many births with frequent intervals. Motherhood is considered as the only way for women to gain a social status and achieve personal success in many patriarchal societies. The role of motherhood is an obstacle for women to benefit from social opportunities. In developing countries, women are observed to be an authority only in the home environment and household and their areas of authority to expand when they have children. Furthermore, having many children is another factor giving rise to the status of women. High fertility provides to women an important prestige and authority, while at the same time this situation prevents the development of women in the social and occupational area, limits active participation to the social life and causes them to remain at the status of second-class (Akın and Mihçioğur, 2003: 130-131).

There are several studies reporting an increase in fertility of women by the rate of low status. In the studies conducted in many developing countries, number of children is observed to decline with the rise of the women's educational status. The most important cause of the difference between the regions in access to services related to birth is indicated as the women's educational status. Maternal mortality is an important problem in developing and less-developed countries. In all the research, dimension of the maternal mortality appears to be in line with the status of women in that society. A woman with low status cannot decide by herself and acts according to the wishes of her family and husband. She cannot receive adequate access to health service, antenatal care and postpartum care services. Consequently, maternal mortality is seen due to reasons such as over fertility, high number of risky pregnancies and being unable to benefit from the health services (Akın and Mihçioğur, 2003: 130-131).

The effect of gender on men's health is not attached much importance. However, there have been newer studies recently about the potential health risks of men. Considering they have facilities to

access to various resources, opportunities and privileges men are expected to be healthier, although living as a man may be risky as well as being favorable (Doyal L, 2000: 4-5).

Ertürk states that a partiality and inequality in the field of health are not a common case, and both men and women are negatively affected by poor health conditions, but women experience this in a different way. Domestic violence; poverty and economic dependency; limited power of supervision on their own sexual and reproductive capacity, especially in women living in rural areas and regional inequalities in development are indicated as the factors negatively affecting the women's health (1997: 41). However, gender may negatively affect the men's health also in some situations. Men can work for very long times as to their physical and mental health might deteriorate in the communities in which men expected to provide family living. Some of the feelings and moods force them to risky behaviors in order to prove their manhood. Similarly, the social expectation of "real man" makes difficult for men to feel themselves weak and seek help. Occupational accidents, homicides, traffic accidents and death from dangerous sports activities are seen more in men. Alcohol and tobacco abuse are more common among men in many societies, and this promotes their biological tendency to heart diseases (Akın, 2005: 2; Doyal, 2000: 4-5). Gender discrimination appears to have negative health effects on both genders. However, women's social status and difficulties in access to opportunities as well as the health problems which they experience 3 folds more than men due to the features of their reproductive health are an indication of how much a disadvantaged position in this regard had women.

Gender-based discrimination and violence can spread in almost every area of life by retaining women from the full use of fundamental human rights and preventing the use of facilities and opportunities (UNFPA, 2006).

Besides the imbalance in use of the facilities and opportunities, another form of discrimination pushing the women into a more disadvantaged position is violence. Violence is a fact learned and transmitted. Of abused children, 30% apply violence in their adulthood, while this risk is seen by 2-4% in children who did not expose to violence (Subaşı, N. 2003: 238). In sociological evaluation, society meets aggression of men as usual, whereas women are expected not to show violent behaviors.

Importance of the violence against women reaches to a very large extent. Violence against women has effects on every aspect of women's life, their own health, health of their children and the larger community. Status of inequality sustains the violence and transforms it to a constant state. For example, domestic violence is associated with poverty, but at the same time this limits the women's outside opportunities and their freedom of access to knowledge and freely strolling, making the

poverty constant. This complicates women to care themselves and children and may push them to self-harm behaviors such as using alcohol and drugs. Furthermore, this situation limits women's self-esteem, sense of autonomy, ability to feel and act independently (Moreno, 1999a, p.8).

Women to experience violence is an important health problem and a case of violation of women's rights. Other health problems are also observed to increase in the women who exposed to violence (Özaydın N, Üner O, Akın A, 1998; Vahip I, 2006; 17(2): 107-14).

Violence against women, a problem in which women are in a disadvantaged position is one of the major threats of the economic development and seen as a crucial obstacle to the development. Despite violence against women is seen as an obstacle to development as a problem of public health and human rights with an increasingly awareness, this type of violence is still not considered sufficient priority for planning, scheduling and budgeting in the international development agenda (WHO, 2005b).

Violence against women is defined as every kind of gender-based behaviors hurting and harming women, likely to be resulted in mental damage, leading application of pressure on them and arbitrarily limiting their freedom in the community or in private life (WHO, 1993, Violence Against Women).

United Nations Declaration of Violence Against Women (1993) describes the gender-based violence as physical, sexual and psychological violence occurring within the family and society, including beating, sexual harassment of girls, violence related to bride price, marital rape, female circumcision and the other traditional practices harmful to women, violence out of the spouses, harassment and intimidation in work places, education institutions and other places, woman trafficking, forced into prostitution and violence applied or condoned by the state (BMMYK, 2001: 10). In all these cases, gender differences in power and other inequalities play an important role in dynamics of the violence and especially in the event of armed conflict; women may expose to certain forms of the violence including rape.

Violence against women most frequently occurs within family. Performer of the violence is always the man who is closest to the women. The violence usually emerges as physical, sexual, emotional or as a combination of these. In general, it is applied on women and children by men. Domestic violence against women may occur in form of physical like beating, sexual or psychological ill-behavior and is usually repeated (Özaydın N, Üner O, Akın A, 1998).

Domestic violence is defined as all forms of violence from a person to another in order to force, insult, showing power or let off the anger and stress, taking place in private area in a group with

blood relation or legal bond which lives together and briefly identified themselves as a family (Moreno, CG. 1999b: 354; Özyaydn, Üner, Akın, 1998: 3-4).

Violence against women, especially domestic violence and sexual abuse, causes many negative health outcomes. These can be seen in a wide spectrum, including injuries and offenses of various degrees leading also to transient disability and hearing loss, sexually transmitted diseases and HIV/AIDS, undesired pregnancies, gynecologic problems, inflammatory and painful gynecologic diseases, hypertension, anxiety, posttraumatic stress and depression, headaches and many psychosomatic reflections.

Although violence is accepted among women to cause injuries, its effects on women's mental, sexual and reproductive health are less recognized and given attention (Moreno, 1999a, p.8-9). There are a large number of studies reporting evidence about women to be affected and harmed biologically, physically, mentally or socially from the violence they experience.

According to the results from these studies, women and girls are under the significant danger of HIV/AIDS infection through sexual abuse. A multi-national study by WHO reports that serious studies are needed in the field of public health in order create an extensive social awareness of the problem, and it should be focused on the place in which the violence is applied (WHO, 2005b).

In this context, health professionals have an important responsibility. The studies investigating causes of indifference about the violence against women demonstrates that the main problem preventing to deal with this issue prevented is the prejudices. Including a gender-sensitive perspective in the education program of the health care personnel is seen important in elimination of inequalities which the women would experience during the violence they might experience and utilization of the health services.

According to WHO Multi-Country Survey on Violence against Women in the Family Study in which 24 thousand women were interviewed, 13 to 61% of the women were found to experience physical violence, while the incidence of sexual violence was between 6% and 59%. The study reports that the most common form of the physical violence which the women experienced was "being slapped," while forms of the heavy violence differed between 4% and 49% included being punched, kicked, drifted on the ground and threatened with a gun (WHO, 2008; WHO Media Centre, 2008; Paksoy, N, 2007: 194-195).

An important proportion of the women think that they deserved the violence they experienced. According to Turkey Demographic and Health Survey 2003, 39.2% of the women reported that their husbands were right about applying violence. This rate decreased to 25% in the results of

TNSA 2008. In that study, the women reported that they deserved to be beaten by their husband in at least one of the cases including burning the food, counteract against the husband, spending money unnecessarily, neglecting of care for children and rejection of sexual intercourse. This rate was 47.8% for the women living in Central Anatolia Region in TNSA 2003 and % 45 in TNSA 2008. "Spending money unnecessarily" was the most accepted cause of physical violence among the women living both in urban and rural areas (TNSA, 2003, s. 40; TNSA, 2008, p: 196).

In a cross-sectional study conducted in Bolu province, prevalence of reported physical violence among housewives was found as 41.4%, emotional violence 25.9%, sexual violence 8.6%, any controlling behavior 77.6 and rate of physical violence experienced in any period of life was found as 50.9% (Mayda AS, Akkuş, 2003: 13). In a field study conducted in Istanbul, 85,9% of the participants agreed with the idea of the violence increases by the rate of it is approved in society (Sözen, Tüzün, Dokgöz, Fincancı, 1999; 4).

Women still expose to various types of the violence. Insufficient understanding of the causes of violence against women negatively affects the works made to eliminate the violence. Lack of the studies about violence and the available data make difficult to better understand the problem and develop policies based on the available knowledge (KSSGM, 2003: 16-17).

Causes of the violence against women vary. These are described with the psychological, biological, sociological and feminist perspectives. Aggression provides success and superiority for men and means a positive power referring to as courage, being strong, energy and agility. In fact, in evaluation from a feminist perspective, violence against women is reported to be sex-oriented and to focus on power. Deprivation and oppression are important elements in emerging of violent behaviors, and a negative mood resulted from low level of income, and limited resources increase the level of stress, leading to violent behaviors (Subaşı, N; 2003: 238). Performers of the power oriented violence against women are generally their spouses or the persons which they live together, which is arisen from the male-dominated society structure.

Women expose to forms of violence, including physical, psychologic, sexual, economic, controlling and neglecting. One of each five women is estimated to experience types of violence, which in some cases may result in injuries and death in their lifetime. Today, violence against women is recognized as a global problem based on the efforts of women's organizations and evidence from the studies by WHO (WHO, 2005b: 3).

Violence against women has effects on every aspect of women's life, their own health, health of their children and the larger community. Studies indicate the incidence of violence and its role in

occurrence of the diseases is being increased. The violence prevents benefiting from the health care services such as reproductive health and family planning and causes to psychological problems, especially during pregnancy and in the postpartum period. Therefore, violence against women and its health outcomes appear to occupy an important place among the inequalities seen in the field of health.

It is seen important health care professionals to act with the sensitiveness of gender when performing their duties for elimination of the troubles which women face during receiving service and for diagnosis in case of exposing to violence. In this sense, this study was designed to define that to which extent weak position and low status of women created by social equalities affects utilization of health services and how do gender oriented attitudes and judgments reflect to the attitudes of health care personnel.

Problem of the research consisted of that to which extent do health care personnel working in Kızılcahamam State Hospital and Health Center and people in the region have the sensitivity for gender equality and which forms do the gender oriented approaches of the society take in benefiting from the health care services.

Purpose

In this study, we sought to learn that how do gender oriented practices function in maintenance and organization of health services, how personnel in the health care facilities to play a role in gender discrimination and which forms do gender oriented approaches of the society take in utilization of the health care services. Main objective of the study was to define the extent of gender sensitivity which health care professionals have and gender oriented approaches of the society about benefiting from the health care services.

Method and material

In this study, descriptive model was used with the qualitative and quantitative research techniques together. The research has two universes. First is the community living in the region of Kızılcahamam primary health care clinic and the second is health personnel working at hospital and primary health care clinic in Kızılcahamam. Data of the research was collected from a sample selected from the first population and a study group of the second population.

After the approval from Kızılcahamam Governorate to conduct the study in the region in April 2008, first universe of the study was defined by analysis of the recordings on Health Center Household Identification Cards. Collecting of the quantitative data was carried out on the sample

selected with proportional stratified sampling method from the universe consisted of the local people in the area of Kızılcahamam County Health Center.

The sample size was found as 361 and extent of the sample stratum was calculated for each region. One hundred and six houses from the first region, 115 houses from the second and 141 houses from the third region constituted the sample size of 362 houses. One person from each house, woman or man who approved was interviewed. In this way, a total of 362 persons as 218 female and 144 male participants were interviewed.

Health care personnel working in the hospital and health center constituted the study group. Sampling was not applied in this group and persons which can be contacted and accepted the interview from the small number of the personnel constituted the study group. In-dept interview method was applied to this group through a pre-prepared questionnaire form. Of the personnel which agreed to be interview; total 27 health care personnel consisting of 3 specialists, 4 general practitioners, 8 nurses, 3 midwives and 4 health officer working in the hospital and 1 general practitioner, 3 nurses and 1 midwife working in the health center were recorded by the researcher, and the data were evaluated with content analysis.

The necessary data for this study were collected in two ways:

Questionnaire method:

Semi-structured questionnaire forms were applied for collecting data about the general gender oriented attitudes of public, gender oriented attitudes and judgments during utilization of the health care services and the participants' observations about gender oriented approaches of the health care professionals. The questionnaire consisted of total 49 question items, including 12 questions for demographic information of the participants, 13 questions to define their attitudes against discrimination in social life and 24 questions to identify the discriminatory approaches observed during benefiting from the health care services. The last 5 questions were prepared as open-ended. In these questions, gender discriminatory attitudes of the public and health personnel in delivery of the services, experiences about the violence and attitudes of the health personnel and public in these events were questioned. In addition, observations and experience observed by the participants in their family or environment regarding discrimination between girls and boys were asked with the last two questions.

In-depth interview

In-depth interviews were made to the physicians, midwives, nurses and health officers who have witnessed gender oriented approach of the public during utilization of the health care services and social gender insensitivity during delivery of the services. An interview form consisted of similar questions was prepared for the in-depth interviews made with health personnel. In this form, questions were involved about the gender oriented attitudes shown by the public during utilization of the services, whether is there any discrimination between girls and boys, presence of gender oriented attitudes of health professionals, attitudes of the persons who have subjected to violence and health personnel in cases of the violence, their role about elimination of the discriminatory attitudes of the public and their recommendations on the subject. The interview form consisted of 6 questions about the demographic data and 7 questions for observations of the gender discrimination.

Percentage and frequency technique of the descriptive statistic was used in analysis of the quantitative data and chi-square method of the inferential statistics was used to test the significance between the variables. The quantitative data were analyzed with SPSS package software.

Open-ended question and the data obtained with interview method were subjected to content analysis without a concern of quantification,

Data collection tool was coded as follow:

PW: Public Woman

PM: Public Man

Interview forms were coded as follow:

I-HPS: Interview – Health personnel specialist

I-HPGP: Interview- Health personnel general practitioner

I-HPM: Interview – Health personnel midwife

I-HPN: Interview – Health personnel nurse

I-HPHO: Interview – Health personnel health official

Research questionnaire was applied between May and June 2008, while interview forms were conducted in June and July 2008. For conduction of the questionnaire, houses randomly defined according to the sampling were visited and the application was carried out through face-to-face interviews by the researcher himself and 6 interviewers trained by the researcher.

Results and Discussion

Of the participants, 36.5% were aged between 36 and 45 years and 60.2% of them were female and 39.8% male participants. Of the interviewees, 89.2% were married, while one participant had 1 imam and 1 civil marriage at the same time. Of the participants, 60.2% reported the monthly income of their family as medium level. % 89.2 of the interviewees had both civil and imam marriages. About half (43.6%) of the participants were primary school graduated, while all of the illiterate (6.0%) and literate (5.5%) participants were women. All the male participants were at least primary school graduated, while 11.5% of the female participants were illiterate or only literate, indicating the research group did not benefit from educational opportunities and facilities on equal footing. 83.5% of female and 20.1% of male participants were not working in a paid job. 89.6% of male and 15.4% of female participants have non-working spouses.

Gender Discriminatory Attitudes of the Public in Social Life

Of the illiterate participants whom all of them were women, 7 reported they did not attend to school because “Their families did not allow them” and 5 due to transportation problems. When the causes of discontinuance to school were examined, female participants reported more (49.7%) they did not go to school because “*Their families did not allow them,*” while this option was lower among the causes of the male participants. The causes of discontinuance to school in men were centered more in “*Have to work*” (32.8%), while they stated causes such as “*not to want attending to school, being unable to understand and working in the family business*” in the “other” option. Rate of discontinuance to school “*Because of the marriage*” was found higher in the female and “*Have to work*” in the male participants. This indicates to the intense presence of the gender oriented elements in the society and to the social status of women. Of the male participants who have non-working wives, 49.3% stated that they don’t want their wives to work in a job.

Some judgments regarding women and men, which are thought to be prevalent in the society were given and the interviewees were questioned whether they agree with these propositions, and important information was obtained regarding gender discrimination. The proposition of “*Men provide continuation of the bloodline*” was approved by 70.2% of woman and 82.6% of man participants, while the proposition of “*Women should choose a job appropriate for themselves*” was accepted by 86.2% of female and 93.1% of male participants. Rate of the interviewees agreed with the view of “*Women should not work without the permission of her husband*” was found as 65.6% in women and 87.5% in men. The proposition of “*Men are responsible for the livelihood of the house*” was accepted by 60.5% of women and 76.1% of men. Rate of considering housework such as child care and cooking as a “job of women” was 69.1% in women and 79.7% in men.

96.3% of female and 96.5% of male participants stated they don't agree with the view, of "*There is no need to educate girls*". However, proposition of "*There must be more control over the social life of girls*" was accepted by 83.9% of women and 91% of men. Majority of interviewees who think girls must be educated agreed with the view of "there must be more control over the social life of girls", suggesting they prefer a more prescriptive and oppressive growing style for girls in order to protect them and discipline them. More than half (55.5%) of women and approximately three out of four (72.2%) of men agreed with the judgment of "*Women are in need to be protected by men.*" Although the participants justify honour killings in the name of restore one's honour were few in the number, having such a thought is considered as an important evidence indicating them to have gender discriminatory attitudes.

Rate of the participants who consider the thought of "*women may be exposed to violence by their husband when it is necessary*" as normal was found as 15.6% in women and 31.9% in men. Proposition of "*Women sometimes deserve beating*" was accepted by nearly one fourth (25.7) of female and about half (46.5%) of male participants. Here, proportional superiority of men might be explained by being mostly who apply the violence, but although with a lower rate, women to justify the violence to be applied on them is considered as a significant evidence and the society to have this type of beliefs and judgments is seen as a barrier to the process of women's empowerment.

Data obtained from this picture indicates: traditional roles of women and men were found appropriate by the majority of the participants; vast majority of the participants accepted the views of "*men provide continuation of the bloodline; they are responsible for earning living for their family and protecting the women; women must work in appropriate jobs with permission of their husbands; housework such as child care and cooking are jobs of women and social life of girls must be more controlled*" and finally, there was a widespread gender discriminatory attitude in the research group.

A study reports 16.5% of women stated that "*women can be beaten by their husband in the case of being wrong and this is normal*" (Deniz, G; Babacan SS, 2008). This indicates that women have developed an awareness of deserving the violence they experienced and that perception of men can beat when necessary is widespread.

42.5% of all the participants stated they prefer male children. Preference of male children showed significant difference between female and male participants. Male children expectancy was increased in men.

According to data obtained from open-ended questions, behavior patterns to girl and boys and expectancies from them were observed to differentiate in observations of the parents themselves

and their environment. These differences were less in utilization of the health care services, while they gained intensity in the issues such as education, social experiences and share of heritage. The female participants who conducted their observations on the discriminations which boys and girls have suffered stated these were often seen in heritage (28%), nutrition (21%) and education, while there were also experiences of discriminations between girls and boys in the areas of economic support, freedom and health. Some words used in these situations are valuable in showing the behavior of discrimination, and some of the selected words are as follows: “Boys have a stronger shadow (HK-13), “You are the bread of another person; its is a loss what you eat and what you wear”(HK-218), “Boys are one span greater” (HK-137), “Wind throws the spall without oppression” (HK-72), “They don’t send the girl to school. Aren’t they girls? What will they do with going to school” (HK-208).

Gender Discriminatory Attitudes of the Public in Utilization of Health Services

In this section, we sought to learn forms of the utilization of health cares in the health centers and differences in the gender-based behavior patterns.

Table 1: Distribution of the status of avoiding to be examined by a physician from the opposite sex in terms of Gender

Status of avoiding to be examined by a physician from the opposite sex	Women		Men		Total	
	n	%	n	%	n	%
YES	63	28.9	19	13.2	82	22.7
NO	155	71.1	125	86.8	280	77.3
TOTAL	218	100.0	144	100.0	362	100.0

p<0.05 (0.000)

Status of the participants to avoid to be examined by a physician from the opposite sex is shown in Table 1. This status showed a significant difference between women and men. 29% of female participants avoided to be examined by a physician from the opposite sex, while 71% stated they don’t feel discomfort. Whereas 86.8% of male participants are seen not to feel discomfort in this case. Women avoided more to be examined by a physician from the opposite sex than men are consistent with more intense feelings of traditional perception and “privacy” in them.

Status of feeling discomfort to receive family planning (FP) services from a physician of the opposite sex was investigated. This status showed a significant difference between the genders. While about 70% of female participants stated that they don’t feel discomfort, this rate was found as 85.7% in male participants. Low rate of the women was interpreted as a gender-based attitude.

Status of male participants in receiving FP services from a physician of the opposite sex and avoiding them wives to receive birth and FP services from a male physician were compared, and a significant difference was found. 66.1% of male participants who stated they don't feel discomfort to receive FP services from a physician of the opposite sex reported that they felt discomfort for their wives to receive FP services from a male physician. This was seen as a contradiction to feel discomfort for their wives to receive health service from a male physician when they don't hesitate to receive this service from a physician of the opposite sex. This situation indicates to the unequal position of women and men.

Opinions on whether women or men should use FP methods were investigated. Responses to this question showed a significant difference between the genders. More than half (55.9%) of the female participants stated that women should use FP services, while more than three-fourth of the male participants reported that they preferred women to use these services. Women feel more responsible for themselves in terms of FP, while men were tended to see this as a responsibility of women rather than men.

Status of the male participants avoiding to be examined to a physician from the opposite sex in their urology problems and their wives to receive birth-FP services from a male physician were investigated. Almost two-thirds (66%) of the male participants stated that they don't hesitate to be examined by a female physician for their urological problems, while 41% of them don't want their wives to receive birth and FP services from a male physician. Although the majority of male participants did not have a major drawback both for themselves and their wives (birth and FP services) to receive service from a physician of the opposite sex, persistence of a group who don't hesitate to be examined by a female physician but don't want they wives to receive birth and FP services from a male physician is considered as a remarkable example of discrimination.

It was reported in the interviews made with the health professionals that the patients have discriminatory attitudes between girls and boys, but these were fewer in the area of health. In rare cases, discriminations in the area of health intensify in nutrition, treatment and vaccination.

Health personnel stated that the sensitivity shown by the patients in treatment, nutrition and vaccination of boys was not shown for girls, and some of the vaccines were not made for the boys with the concern of infertility.

According to the data obtained from the open-ended questions, most common discriminatory attitudes of the participants were preference of the health personnel based on gender. Accordingly, although predominantly female patients, both genders were seen to prefer receiving service from

their counterparts in the operations such as dressings related to the sexual organ, catheter insertion and injection.

Similarly, although few in the number, there were physicians, nurses and health officers avoiding examining their patients from the opposite. This gained intensity in dressings of genital organs, injection and insertion of catheters. The responses received both from the public and health care professionals indicate that health personnel apply discrimination based on gender, socio-cultural level, educational status, appearance and well-grooming of their patients.

Health personnel also exhibit discriminatory attitudes in themselves. Data obtained both from the male and female health professionals indicate that female health personnel were in a more disadvantaged position in terms of self-expression, working environment and seeking their rights.

Health personnel were found to be mostly understanding, problem solver and guiding in the patients exposed to violence, but there were also negative attitudes.

Results on the Violence Perceptions and Experiences

In this section, quantitative results on the participants' definitions of violence, their opinions and experiences about the violence and qualitative findings obtained from the open-ended questions are discussed.

Table 2: Distribution of Definition of the Violence Based on Gender

Violence definition	Women n=218		Men n=144		Total n=362	
	n	%	n	%	n	%
Physical	89	20.5	71	25.9	160	22.6
Psychological	60	13.8	43	15.7	103	14.5
Sexual	63	14.5	48	17.5	111	15.7
Controlling	33	7.6	15	5.5	48	6.8
Economical	46	10.6	23	8.4	69	9.7
Negligence	17	3.9	9	3.3	26	3.7
All of them	126	29.1	65	23.7	191	27.0
TOTAL	434	100.0	274	100.0	708	100.0

* One participant ticked more than one option. The analysis was carried out according to the responses.

Participants' perception and definition of the violence are seen in Table 2. Total number was high because of more than one option were ticked.

The participants, mostly (22.6%) defined the physical violence as the "violence," while 27% of them defined it with all physical, psychological, sexual, controlling, economic and negligence dimensions. Controlling and negligence were defined as violence by the least rate. In this approach,

it was thought that women and men internalized the values of the society in which they were adopted the position of women and thus don't consider the controlling or supervising behaviors of men as violence and see them as normal or another negation other than violence. Causes of participants not to perceive controlling behaviors as violence might be clearer considering men to protect and look after women; earning living of the family to be the responsibility of men or women not to work without permission of their husbands.

70.3% of female and 59.9% of male participants stated they were completely against violence. Rate of the participants believed "women may have caused" to violence against them or "this is a private matter between two people" was found higher in men. Percentage of the male participants who agreed with both propositions was 36.8; suggesting men might justify the reasons for violence against women and approve the violence in some cases.

This result might be found odd since mostly men are the perpetrator of violence, but it is evaluated as a dramatic and important evidence the female participants to believe they might cause to violence even by 6.4%; to largely see themselves as the reason of violence event or one out of each 5 woman to consider the violence as a private matter between two people, indicating women internalize the violence, consider it as normal albeit reluctantly and the violence to become usual in their daily life.

Table 3: Distribution of Domestic Violence According to Gender

Status of exposing to domestic violence	Women		Men		Total	
	n	%	n	%	n	%
YES	117	53.7	29	20.4	146	40.6
NO	101	46.3	113	79.6	214	59.4
TOTAL	218	100.0	142	100.0	360	100.0

P<0.05 (0.000)

Table 3 shows distribution of exposing to domestic violence according to gender. Exposing to domestic violence showed a significant difference between genders. Rate of the participants who exposed to domestic violence was 53.7% in the women and 20.4% in men. Both gender might be exposed to violence, although women are known to be most exposed to violence in all societies. In this study also women were found to be exposed more to violence.

In another study, 37.2% of women were reported to suffer violence (Verim E, Sohbet R, 2009: 468). Although the incidence of violence was lower compared to research group, participants'

definition and perception of violence and socio-cultural determinants were believed to be effective on this rate.

In a study conducted in Fethiye, 40% of women are reported to suffer domestic violence, and the perpetrators of violence were their spouses (Deniz, G; Babacan SS, 2008). Besides percentage of exposing, type of the violence is also important. Women are exposed to violence more from their spouses and followed by the other male figures in the family.

The perpetrators of violence were fathers, elder brothers and other persons (non-family) in men, while they were male figures of the family such as husbands (57.8%), fathers and elder brothers. Except these figures, female participants reported in the "other" option that they suffered violence by the persons in their close environment such as "mothers, sisters, mothers-in-law, fathers-in-law, brothers-in-law and stsrres-in-law".

In a study investigating violence against women, 86.2% of the women were reported to be exposed violence from their husbands (Verim E, Sohbet R, 2009, p.468).

When type of the violence evaluated, comparison of women and men was seen quite dramatic. The female participants stated they mostly suffered physical (45.9%) violence followed by psychological (24.2%), sexual (3%), controlling (13%), economical (4.8%) and neglecting (9.1%) forms of violence. Whereas the male participants mostly suffered physical violence, while they experienced the other types of violence less than women. When inter group percentage of women and men were evaluated in themselves, women should not be considered to expose less to the physical violence (45.9%), because they quantitatively suffer more all forms of violence.

Incidence of physical violence against women was found as 13-65% in WHIO Multy-country Research of Domestic Violence Against Women, 25.2% in "Prime Ministry Family Research Council Study" conducted in 1997 and 50.9% in a study by Mayda and Akkuş (WHO, 2008; Mayda, AS; Akkuş, 2003, p.13). The results of these studies were similar.

In a study by Verim and Sohbet, incidence of physical violence against women was found as 84.5%. In the same study, 37.2% of the women stated that they suffered violence (Verim, E., Sohbet, R., 2009, p.468). Accordingly, people in the region were thought to have different perceptions on definition of violence. In that study, incidence of the violence against women was found as 53.7%, while 45.9% of these events were defined as physical.

In a study investigating the women who applied to the shelters due to violence they experienced, women were reported to suffer more than one type of violence. Evidence from this study indicated that by 87.7%, of the women suffered verbal, 83.1% physical, 80% emotional, 60% sexual

and 50% economical violence and that the violence prevented benefiting from the health services such as reproductive health and family planning (60.0%-53.8%) and caused to troubles like psychological problems with a high rate (52.3%-50.8%) especially during pregnancy and in the postpartum period (Çiftçi Ersoy, Ö; Yıldız Eryılmaz, H, 2006).

82.4% of the female and three out of fifth of the male participants stated that they were physically or emotionally hurt based on the violence. Rate of the women participants who stated they had not physically and emotionally hurt was 17.6% (n=9) which was evaluated as thought-provoking and unrealistic interpretations and human nature were believed to be definitely affected from all types of violence even with different forms and levels. Non-suffering any physical health problem should not mean the person who exposed to violence was not hurt anyway. 93.3% of those physically or emotionally hurt based on the violence were the female participants.

Of the participants who presented to a physician due to violence, 8 female and 1 male reported that they shared the violence with the doctor. In both genders, there was a tendency outweighing to hide the violence from the physician, while they found to visit the physician only for treatment, and the men were found to more often hide their experiences from the doctor.

Attitude of the physician against the persons suffered violence was evaluated with the data collected from 10 women and 2 men who presented to a physician. Of the participants presented to a physician due to violence those agreed with the option of “*The physician treated me, compiled a forensic report and started the necessary legal proceedings*” were consisted only from the women. Evidence from the data indicates that the physicians did not compile a report in every case, they approached more in a treatment oriented way, and they could guide. In addition, another option involved in this question, “*The physician acted as blames and judges me*” was not ticked by both participant groups, suggesting attitudes of the doctors were largely seen positive.

In the data obtained from the open-ended questions regarding violence, there were some discourses in the research group which justified women to suffer violence and almost normalized this situation. These words were remarkable evidence from the research group, reflecting their opinions and perceptions about the violence: “*Wind throws the spall without oppression*” (HK-72), “*There is obviously a guilt for him to beat*” (HK-208) “*The peace does not taste without being offended*” (HK-138). These words are culturally internalized and are opinions, which normalize and might justify the violence or beating and advocate it could be occasionally used as a tool to provide the discipline. This understanding leads to a loss of status in the traditional structure. It is intensely reported both by the health personnel and participants that psychological problems are often encountered in the women due to cycle of alcohol and violence and the resultant traumas in

Kızılcahamam. Some participants expressed the violence which they suffered as “*I only had slapped, but I had deserved this and did not go to a physician*” (HK-11, HK-60) and this was seen as an important clue to reach this judgment.

As it would be understood from the statements, people mostly exhibited gender based discriminatory attitudes, although they were not aware of this approach is discrimination.

Conclusions and recommendations

At the end of the research, according to the data obtained both from the public and health care professionals, obvious gender discriminatory approaches were found in utilization and delivery of the health. This indicates to:

- The need for education in order to eliminate gender discriminatory approaches in utilization of the health care service by the public;
- The need for education in order to improve sensitiveness of the health professionals about the gender discrimination;
- The need for both pre-service and in-service training in order to eliminate discriminatory approaches of the health professionals.

However, this study was limited by the sampling taken from the public of a county, and the data obtained from the interviews made with the health personnel working in a health center and in a hospital. Therefore, further extensive studies are needed to investigate this issue.

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