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In Bangla There Is No Word for Vagina

—Reflections on Language, Sexual Health, and Women’s Access to Healthcare in Resource-Limited Countries

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Abstract

Language plays a central role in how gender and sexuality are described. In Bangla or Bengali, physicians, when educating and counseling women patients, do not have a socially acceptable word for “vagina”. If language is missing for female genitalia or important female sexual functions, could this absence reflect on the position of women in society, reproductive rights, and access to healthcare? Is there a relationship between language and the high rates of the gender-based cervical and breast cancers in some low and middle-income countries? This commentary examines scholarship on the topic of language, the female body, gender-based violence, disparities of healthcare for women, and the consequences of language on sexual attitudes and health.

Keywords

Vagina, Gender-Based Violence, Language, Bangla, Reproductive Rights, Cervical Cancer, Bangladesh, Healthcare Access, Social Determinants of Health

1. Introduction

Social Determinants of Health (SDOH) identify non-medical factors that impact both the incidence and the outcomes of medical conditions. SDOH include social, cultural, and economic factors that influence the health of individuals and populations [1]. In addition, they include factors such as lack of access to transport, social exclusion, poverty, social barriers and taboos that serve to deprive individuals of healthy lifestyles or access to health care [2]. The World Health Organization’s (WHO) Commission on Social Determinants of Health identified the importance to SDOH of structural mechanisms, which are rooted in the socioeconomic and political context of each specific

nation. Within the structure of each society, the following key factors influence health: Income, Education, Occupation, Social Class, Gender, Race/Ethnicity [2].

Women can face particular challenges to receiving healthcare because of cultural norms that favor both economic and political opportunities for men. The SDOH for women include nutritional deprivation, neglect, and sexual violence that lead to poor gender-specific health outcomes such as high maternal mortality, and mortality from cervical and breast cancer [3]. Health inequities are differences in health and disease that are produced by social, cultural, and political factors and are systematic and unfair in their distribution across the population [4]. Is it possible that in addition to well described inequities, language can also contribute to health inequities for women? An example of this is that in Bangladesh, there is no socially acceptable word for vagina (see Case Study). Does the lack of specific words for female anatomy reflect other cultural influences that correlate with SDOH and influence health outcomes for women?

There is a direct relationship between women's political rights, social status and their access to healthcare [6]. Passive and active neglect of females worldwide through selective abortions, lack of nutrition, violence, and lack of medical care has led to an estimated loss of one hundred million women [7] [8].

A review through the World Health Organization of gender-sensitive policies and general health policies in five South Asian countries show that large gender inequities still exist in political and economic status, birth sex ratios, human trafficking, illiteracy rates, maternal mortality rates, contraception prevalence rate, fertility rates, knowledge of HIV/AIDS prevention, access to skilled birth attendants, and microfinance [9].

This commentary examines scholarship on the topic of language, the female body, gender-based violence, disparities of healthcare for women, and the consequences of language on sexual attitudes and health.

2. Case Study: Language and Cervical Cancer Screening in Bangladesh

We developed open-air teaching sessions in the Korail Slum of Dhaka, Bangladesh as part of a cervical cancer-screening program [5]. The purpose of these sessions was to educate women about their bodies, the risk of cervical cancer, the symptoms of cancer, and how it could be prevented through screening. During these sessions, the Bangladeshi healthcare workers noted that there was no polite word for vagina in Bengali, as the usual word was a foreign word and was used only in the context of sex workers. Therefore, when teaching in Bengali about Pap smears and pelvic examinations, they instead said that an examination would be done of the "mouth through which the baby comes through". Another explanation to women of the Korail slum, "the passage of menstruation", was used to teach women how to use vaginal tablets. Other Bangladeshi physicians, when talking to their patients about their female anatomy, referred to the vagina as "the area of the bladder". In Bengali, the accepted term used for vagina in books is "jonipath" but this word would never be used verbally by physicians when talking with patients.

3. Social Determinants of Health and Cervical Cancer

The incidence of and survival from two leading malignancies in women, gender-based cervical and breast cancer, also correlate with the political and societal rights of women in various countries. Cervical cancer is the malignant transformation of cells after exposure to sexually transmitted, high-risk Human Papillomavirus (HPV) infections. HPV-related cervical cancer has a long premalignant phase before transforming into a cancer and therefore this cancer can easily be diagnosed and eradicated by early screening with pap smears [10]. More recently, HPV vaccination has become available and widespread vaccination of both girls and boys could potentially lead to the disappearance of this disease [11].

Despite well established and inexpensive guidelines for detection, evaluation, and treatment, cervical cancer is a leading cause of cancer-related death in low- and middle-income countries (LMICs) due to lack of screening [12]. A recent comparison of cervical cancer screening in 57 countries revealed a disparity between high- and low-income countries where 63% versus 19% of women were screened respectively [13].

In high-income countries, disparities in Pap smear screening have been analyzed by the social ecology model [14]. The five different levels of social ecology are intrapersonal, interpersonal, organizational, community, and societal; these levels can drive women's access to health care and their ability to navigate health interventions. Cervical cancer screening in developing countries is influenced by SDOH. In a review of original research studies from LMICs, structural (cultural and societal values, socioeconomic position, ethnicity) and intermediary (geographic location, health seeking behaviors, psychosocial factors, the nature of the health system) and issues of social cohesion were all important determinants of access to cervical cancer screening [3]. In an analysis of cervical screening by income-related inequality in 67 countries, there was a statistically significant income-related screening inequality in 50 countries [15]. Cervical cancer screening rates range from less than 1% in Ethiopia and Bangladesh to 83% in Austria.

In Bangladesh, there are over 150,000 cases of cervical cancer each year and the majority of women with this cancer are identified with stage 3 or 4 disease [16]. Because of inadequate treatment facilities, most of these women will die from their cancer [16]. Lack of screening is the primary reason for this catastrophic rate of gender-based cancer in Bangladesh. The SDOH directly apply to the reasons for neglect of women's health in Bangladesh. There is a relationship between lack of screening of a sexually induced cancer and cultural attitudes towards women. Thus the incidence of cervical cancer and the death rate from cervical cancer can be used as a proxy for adequate healthcare for women.

4. Bangladesh: Culture and the Status of Women

Bangladesh is a hierarchical society where people are respected because of their age and position. Bangladeshis expect the most senior male to make decisions for the family and for their particular group [17]. Bangladesh is a classic patriarchal society where gender defines social roles and power relationships [18]. Healthcare decision-making falls to

the husband in a household as men dominate the decision making for large financial purchases such as healthcare. In the absence of education about the consequences of medical delay, decisions based solely on financial concerns can be detrimental to the women in the household. For instance, a study of antenatal care and outcomes in rural Bangladesh demonstrated that health outcomes were worse when only the man was involved in decision making (like family planning choices) compared to joint decision making between the couple [19].

Women in Bangladesh face an unequal legal status and an inferior cultural position [20]. Traditionally, women have not been visible on the streets and parks. While this has changed in the past 20 years with the rising middle class, women continue to be confined to the domestic space for safety. Women's sexual roles are meant to be private and controlled and not public and expressive. Women who lack the power to negotiate safe sex with their partners can suffer from HIV/AIDS and other sexually transmitted diseases. Women's sexuality has been controlled through sanctions ranging from social ostracism to death [21]. The reasoning of the husbands is that if women could enjoy sexual relations and could prevent pregnancy, sexual monogamy and family security would be jeopardized.

5. Women and Gender-Based Violence

South Asia, a region of eight populous countries is remarkable for high rates of gender-based violence (GBV) and intimate partner violence (IPV) problem. The World Bank funded a comprehensive review of data and performed a population survey of the region. The report, "Violence Against Women and Girls, Lessons from South Asia" exhaustively documents current statistics, references, cultural mores, and laws pertaining to this problem [22]. The prevalence of IPV ranges from 18 to 56 percent with a median of 36%. The World Bank identified the major organizations and programs within each country that played a role in prevention, education, and intervention for survivors of IPV, which was predominantly, gender-based violence (GBV) against women. When analyzing by population, India and Bangladesh were countries with the highest reported prevalence rates of GBV and have the lowest per capita number of organizations to help victims (Table 1). More than half of married men (55%) feel justified in hitting or beating their wives. In a health survey, nearly one in two said if their wife went out without telling them, it would justify violence [22]. Additionally, physical and sexual violence against indigenous minority women in Bangladesh has been increasing and, most commonly, the perpetrators are of the Bengali majority [23].

Bangladesh has one of the highest rates of child marriage in the world. Almost two-thirds of adolescent girls are married and more than half the adolescent girls become mothers by the time they are 19 (The State of World Population, UNFPA). Domestic violence remains a huge threat to the security of adolescent girls. A UNICEF report found that extreme physical abuse at home that led to death accounted for more than 70 percent of the reported domestic violence cases involving young housewives and girls aged 13 - 18 (www.unicef.org/bangladesh). Early marriage and sexual harassment

Table 1. Organizations to protect against IPV by Country.

Country	Population**	IPV Organizations*	Organizations per million pop	Prevalence of IPV (%) in 12 months*
Afghanistan	32,564,342	101	3.1	39
Bangladesh	168,957,745	54	0.3	37
Bhutan	753,947	5	7.0	14.5
India	1,251,695,584	204	0.2	40
Maldives	345,023	32	80	18
Nepal	31,551,305	120	3.8	31
Pakistan	199,085,847	114	0.8	56
Sri Lanka	20,480,000	62	3.0	34

*Solotaroff, J.L., Pande, R. P. (2014). Violence against Women and Girls: Lessons from South Asia. South Asia Development Forum; World Bank Group <https://openknowledge.worldbank.org/handle/10986/20153>; **Geohive: current world population. http://www.geohive.com/earth/population_now.aspx

cause girls to drop out of educational opportunities and to limit their opportunities for social and professional advancement.

Organizations for the help of victims of IPV or GBV range from international groups such as USAID, NGOs such as IOM (International Organization of Migration), to national NGOs, government agencies, or private charities [22]. Most of these programs are part of larger programs that focus of health, education, and nutrition in general. For instance, BRAC Development Institute—Centre for Gender and Social Transformation, is a small program in the largest National NGO of Bangladesh [24].

BRAC's Centre for Gender and Social Transformation (CGST) functions as a research and education group [25]. The information about GBV garnered by BRAC becomes part of their overall mission to reach the impoverished of Bangladesh and improve their health status.

In Bangladesh, the penalty for a convicted rape by someone who is not the spouse is up to life imprisonment. The penalty for rape by a woman's spouse is up to two years and a fine [26] [27]. It is unclear if there has been a change in the laws based on BRAC's advocacy.

One other local organization is Acid Survivor Foundation of Bangladesh (ASF), which works to increase awareness of acid attacks against women and provide care and rehabilitation for victims of acid attacks [28]. ASF identifies acid attacks as a form of gender-based violence (GBV) that targets women to either punish or intimidate and to prevent women from advocating for equal status to men. The most common reasons for acid attacks in Bangladesh include disputes of dowries, rejection of marriage proposals, or women attempting to leave their husbands. A report stated that 165 women were killed in one year, 77 had acid thrown on them, one was divorced and 11 committed suicide over dowry demands (Asian Legal Resource Centre). With publicity and intervention, acid attacks in Bangladesh have dropped from a reported 240 in 2000 to 59

in 2015.

For those women who survive an acid attack, consequences are complex and full of suffering. Women are disfigured. They become social outcasts, and withdraw from school or work. The women suffer from depression, isolation, physical pain, blindness, and post-traumatic stress disorder.

Language may play a role in encouraging GBV. A study of Nepali victims of abuse showed that denigrative language and assault and injury to female genitalia were a major part of their victimization [29]. An ethnographic study from South India that looked at language and culture, identified the key structural inequalities of gender, class, and caste fueling GBV [30]. A women's ability to resist violence hinges on access to economic and social resources.

In summary, IPV is a significant problem in South Asia. While the majority of victims are women who are subject to gender-based violence, men and children can also be targets. Gender minorities are the most vulnerable to attacks because they are rejected by mainstream society and abandoned by their families [31].

From a SDOH perspective, power inequities drive gender-based violence [32]. The historical nature of gender-based violence is systematically entrenched in culture and society, and reinforced and powered by patriarchy [33]. GBV is associated with an increased risk of cervical neoplasia. A study of 1152 women identified a 4.28 relative risk of cervical neoplasia in women victimized by intimate partner violence [34]. The association of GBV and cervical neoplasia may be due to psychological stress, inability to get to medical care or through direct exposure and transmission of HPV from sexual assaults. Language reflects gender roles, power relationships, and risk of GBV [35].

6. Bangladesh—Women and Illness

In countries where women are socially, politically, and economically disadvantaged, high rates of reproductive illnesses and death are common. Outcomes from cancer depend not only on the stage of disease and treatment but other social determinants of health including government programs and community support [36]. Breast cancer and cervical cancer, two most common cancers of women in Bangladesh, are usually identified at late stage due to delay in diagnosis for complex social and financial reasons. Cancer can be considered a curse in certain Bangladeshi populations. Women may hide the fact they have breast or cervical cancer because of fear of abandonment [37]. Divorce is not uncommon when a woman is discovered to have cancer [37]. As an individual example from our screening program in the Korail slum, we cared for a woman with stage four cervical cancer who was abandoned by her husband. Her husband stated that since she was going to die, there was no need to spend money on her for treatment.

Those who lose their families after a cancer diagnosis face additional vulnerabilities. Living alone is another risk factor for increased mortality. A study of mortality differences by marital status in Bangladesh showed that never married and divorced women had a significantly higher risk of dying compared to married women [38]. Other factors

that increase the risk of dying of cervical and breast cancer are listed in **Table 2** [37] [39] [40].

Women may need to get permission from their husbands, in-laws or fathers to seek medical care [18]. About 55 percent of married women lack the freedom to go alone to a hospital or health center, or outside their village, town or city. Almost one in every two husbands decides their wife's health care (48%). For women who reach the hospital, there are other challenges to receiving care. Not only do they have to mobilize significant financial and social resources to fund out of pocket expenses, poorer women face greater challenges in receiving treatment, as relatives are less able to raise the necessary cash. Additionally, limited resources at the health facilities can lead to a "wait and see" policy that can risk the deterioration of a woman's condition before help is provided [41].

There are other dimensions to the financial barriers to care. Currently, there are no health insurance programs in Bangladesh and healthcare is paid for out-of-pocket [42]. The majority of the poor and "ultra-poor" of Bangladesh receive healthcare from non-medical practitioners, government programs, and non-government organizations (NGOs). There are deficiencies and inconsistencies in the quality of services at government hospitals. The staff are poorly paid and understaffed [37]. Traditional healers are cheap and minister to cultural needs but are ineffective in treating cancer [43]. Additionally, there may be a lack of close proximity to the healthcare facility and road conditions are poor [40].

In the city of Dhaka, 30% of the population are slum dwellers [44]. Poverty is an intransigent barrier to care. Within slums, an average of four persons live in one room of 2.4 by 4 meters [45]. Sources of water supply for drinking include pirated municipal taps in public places and sanitation for the area is poor. Disease prevalence rates in the slums are 253 per 1000 people and 30% of the sick persons do not have any treatment at all. In this harsh environment, the rigors and challenges of daily life put women at increased risk for gender violence, neglect, and illness.

7. Language and Women's Sexuality

Language is an inherently unique aspect of the human species. It is the matrix within

Table 2. Barriers to healthcare for women in Bangladesh.

-
- Lack of education and cancer awareness among the general population
 - High rate of non-compliance with treatment due to inability to pay
 - Lack of a centralized medical data-collection system to record outcomes
 - Need for female providers
 - Itinerant nature of city slum dwellers leading to lack of medical follow-up
 - Higher rates of infectious co-morbidities
 - Cultural challenges of modesty preventing pelvic examination and screening
 - High rate of gender based violence
 - Distance from healthcare facility
-

which human society functions and it is extraordinarily complex [46]. There is flexibility and creativity to how each language communicates thoughts between the speakers and the listeners [47]. The Sapir-Whorf hypothesis posits that language not only describes the world of a particular group but also molds how a certain group experiences the world [48]. The consequence may be that a particular culture is limited in their conceptual ability by the defining language. There is controversy about whether cultural beliefs and world-views are implied by a particular language [49].

Language may reflect different cultural conceptions of illness. Warner examined the differences in disease conception among widely varied groups ranging from Navaho, the Nigerian Yoruba tribe, Chinese, and Western European. Explanation of illness is related directly with each group's explanation of its people's connection to the universe and these explanations are related directly to the particulars of each language [48].

It could be that how language occurs and how culture is transmitted is different from the vantage point of men and women [50]. Language plays a central role in how gender and sexuality are described. Historically, there are many examples of downplaying the importance of and denigrating female sexuality in Western literature [51]. Gender stereotypes can even be found in medical textbooks where eggs are described as "passive" and "fragile" while sperm are described as "dominant" and "active" despite scientific data to the contrary [52].

So there seems to be a universal power dichotomy that is reflected in language between males and females in societies from the more affluent West to those of poorer continents. There are clear male-female inequalities that transcend cultures and are not biological but rather social and political [53]. At the level of sexual relationships, gender norms reinforce the vulnerability of women and girl children to adverse sexual and reproductive health outcomes [54]. Even in global health programs, there is an absence of any reflection on gender differences of diseases, which may reinforce inequalities in health between men and women [8].

Bangla or Bengali, the language of 98 percent of Bangladeshi people, has many etymological influences. Bengali evolved from Sanskrit around 1000 of the Common Era [55]. There is a strong Islamic influence seen in greetings such as "Assalamu Alaikum". There is also influence from Hindu and even English [17]. When comparing Bengali to English, English has a far larger vocabulary size [49]. It is important when translating from one language to another to be very wary of potential political and economic as well as "colonial" biases that may alter the meaning of the original language in translation [49] [56]. It is also important to understand the context of the act of translation.

In modern day Bangladesh, the reluctance or avoidance by Bangladesh women physicians to name female genitalia and to use euphemisms could represent no more than current cultural linguistic practices. However, if language is missing for female genitalia or important female sexual functions, could this absence reflect on the position of women in society, reproductive rights, and access to healthcare?

Is there any correlation with language, culture and women's health separate from this universal male-female power inequality? In South Asia, language and sexuality has a

rich history. A fascinating review of Tantric Art examines primordial sexual depictions in the Indus Valley from five thousand years ago [57]. There were many female goddesses and considerable overt sexual acts as part of depictions of these deities. There are numerous references to the union of opposite: male and female, birth and death, creation and destruction, penis (“lingam”) and vulva (“yoni”), pleasure and suffering, the self and the other in these drawings. There are pictures of worship of disembodied vulvas. One wonders how over the millennium, culture in this region evolved from vulva worship to a society where rape and intimate partner violence are pervasive [22] [25] [58]. Interestingly, the Bangladeshi word for sex is “linga” (derived from the ancient Sanskrit word for penis “lingam”).

Speaking about women’s genitalia is a taboo topic in many cultures [59]. A qualitative study of women’s understanding of their female anatomy demonstrated a lack of childhood learning and a silence about the clitoris as adults [60]. Silence and repression about female genitals may be linked to the connection between sex, knowledge, and power in all societies. In one analysis, women are seen as grotesque in patriarchal and postcolonial societies of Asia [61]. The denigration of the female body by men is excused as a response to their own oppression as a result of being colonized and victimized.

“The Vagina Monologues” (TVM) broke the silence in the West with the central message that women have been discouraged from exploring their anatomy and sexuality [62]. In addition, Ensler explored the phenomenon of verbal taboos where verbal utterances of women’s sexuality were considered obscene and threatening to the dominant culture of many nations. TVM went international to mixed reviews. Interviews from different women’s groups revealed varied reactions: for instance some Bangladeshi women embraced the openness, yet women from some other Muslim countries felt offended by Ensler’s “colonial and western” perspective of their societal conditions [56].

Language is a tool for power relationships. There are four fundamental types of power that are relevant to women’s place in society, their ability to negotiate healthcare, and the outcomes of gender-based illness [2] [63]. These include 1) “power over” (the ability to influence or coerce); 2) “power to” (organize and change existing hierarchies); 3) “power with” (power from collective action); and 4) “power within” (power from individual consciousness). The ability to name female anatomy is the first step in a woman having control over her body [62].

8. Conclusions

Women by virtue of their position within families and societies are unequally impacted by the many social determinants of health in Bangladesh. How do language and culture play a role in this unequal treatment? Much ill treatment and violence to women is connected to ways in which their bodies, sexuality, reproductive roles and health are perceived [20]. While the issue of sexuality is central to discourse on rights and freedoms, poverty and deprivation puts women at higher risk of neglect both physically and medically [58]. Gainful employment is linked with survival and conversely, low literacy increases women’s vulnerability.

Is there a word for vagina in Bangladesh? Yes, but it has been changed to euphemism by centuries of a culture that silences women's voices [18] [20]. Whether the neglect of naming vaginas as an important part of a woman's anatomy has led to a catastrophic rate of untreated and untreatable cervical and breast cancers, or whether the language is merely a symptom of other challenges to women's healthcare, the need to both empower women in their sexuality and their medical care is clear. Perhaps with education and advocacy, this Bangladeshi culture will go back to its tantric roots of venerating women's sexual power equally with men's.

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