

CHAPTER-I

CHAPTER - I

INTRODUCTION

We are very much familiar since time immemorial with the saying “Health is Wealth.” Many definitions of health have been offered from time to time but its importance remained the same. The widely accepted definition of health is that given by the World Health Organization (1948) in the preamble to its constitution, which is as follows: “Health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity.” In recent years, this statement has been amplified to include the ability to lead a “socially and economically productive life.” Health is on one hand a highly personal responsibility and on the other hand a major public concern. The importance of health in socio-economic development has also been gaining recognition now a day. Socio economic factors and health problems are interlinked and this is the cause behind the disparity among the developed and developing countries. In the Millennium Summit of the United Nations in September 2000, 191 countries reaffirmed their commitment to working towards a world in which there is sustainable development and poverty gets eliminated. Millennium Development Goals (MDG) took its birth in this summit with the aim to operationalise these concerns. It made the improvement of maternal health as one of its objectives. (Khan & Wakil, 2007).

Health is a common theme in most cultures. In fact, all have their concepts of health, as part of their culture. Among definitions still used, probably the oldest is that health is the “absence of disease”. In some cultures, health and harmony are considered equivalent. Health is often taken for granted, and its value is not fully understood until it is lost. At the international level, health was “forgotten” when the covenant of the League of Nations was drafted after the First World War. Only at the last moment, was world health brought in. Health was again “forgotten” when the charter of the United Nations was drafted at the end of the Second World War. The

matter of health had to be introduced ad hoc at the United Nations Conference at San Francisco in 1945.

However, during the past few decades, there has been a reawakening that health is a fundamental human right and a world-wide social goal; that it is essential to the satisfaction of basic human needs and to an improved quality of life; and, that it is to be attained by all people. In 1977, the 30th World Health Assembly decided that the main social target of governments and WHO in the coming decades should be “the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”, or brevity, called “Health for All”. With the adoption of health as an integral part of socio-economic development by the United Nations in 1979, health, while being an end in itself, has also become a major instrument of overall socio-economic development and the creation of a new social order.

An understanding of health is the basis of all health care. Health is not perceived the same way by all members of a community including various professional groups (e.g., biomedical scientists, social science specialists, health administrators, ecologists, etc.) giving rise to confusion about the concept of health. In a world of continuous change, new concepts are bound to emerge based on new patterns of thought. Health has evolved over the centuries as a concept from an individual concern to a world-wide social goal and encompasses the whole quality of life. As per the new philosophy of health, health is a fundamental human right and an integral part of development. Health is the essence of productive life and it involves individuals, state and international responsibility. Health and its management is a major social investment. Actually, health is world-wide social goal. Health is multidimensional. Physical dimension of health implies the notion of “perfect functioning” of the body. The signs of physical health in an individual are: “a good complexion, a clean skin, bright eyes, lustrous hair with a body well clothed with firm flesh, not too fat, a sweet breath, a good appetite, sound sleep, regular activity of bowels bladder and smooth, easy, coordinated bodily movements. All the organs of the body are of unexceptional size and function normally; all the special senses are intact; the resting pulse rate, blood pressure and exercise tolerance are all within the range of “normality” for the individual’s age and sex. Mental dimension of health

deals with the ability of a person to respond to the many varied experiences of life with flexibility and a sense of purpose. Mental health is a state of balance between the individual and the surrounding world. It is coexistence between the realities of the self and that of other people and that of the environment. Social dimension of health implies harmony and integration within the individual, between each individual and other members of society and between individuals and the world in which they live. It has been defined as the “quantity and quality of an individual’s interpersonal ties and the extent of involvement with the community”. Spiritual dimension of health refers to that part of the individual which reaches out and strives for meaning and purpose in life. It is the intangible ‘something’ that transcends physiology and psychology. It includes integrity, principles and ethics, the purpose in life, commitment to some higher being and belief in concepts that are not subject to “state of the art” explanation. There is another dimension of health called ‘emotional dimension’ which is different from mental dimension of health. Mental health can be seen as “knowing” or “cognition” while emotional health relates to “feeling”. There are various other dimensions of health like vocational dimension, philosophical dimension, cultural dimension, socioeconomic dimension, environmental dimension, educational dimension, nutritional dimension, curative dimension, preventive dimension etc. Though health is a complete medical concept still it has various non medical dimensions too. For this reason, we can not separate an individual from his/her surroundings.

Health is multi-factorial too. The factors which influence health lie both within the individual and externally in the society in which he or she lives. The factors are heredity, environment, life-style, socio-economic conditions, health and family welfare services etc. Health is in one hand a highly personal responsibility and on the other hand a major public concern. It thus involves the joint efforts from all the levels of the society. To protect and promote health there is individual, community, state and international responsibility. At the international level, the Universal Declaration of Human Rights established a breakthrough in 1948, by stating in Article 25: “Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family...”. The preamble to the WHO Constitution also affirms that it is one of the fundamental rights of every human being to enjoy “the highest attainable standard of health”. The Constitution of India provides that health is a State

responsibility and it is mentioned in the Directive Principles of State Policy. India is a signatory to the Alma-Ata Declaration of 1978. The National Health Policy, approved by Parliament in 1983 clearly indicates India's commitment to the goal of health for all by the year 2000 AD. These trends have resulted in a greater degree of state involvement in the management of health services, and the establishment of nation-wide systems of health services with emphasis on primary health care approach.

It is an undeniable fact that health is essential to socio-economic development. It was commonly thought in the 1960s that socio-economic progress was not essential for improving the health status of the people in developing countries, and that substantial and rapid progress could be made through introduction of modern public health measures alone. Thus, role of human beings in the developing process was grossly underestimated. The period 1973-1977 witnessed considerable rethinking on this subject. There was profound modification of the economic theory. It became increasingly clear that economic development alone can not solve the major problems of poverty, hunger, malnutrition and disease. In its place, "non-economic" issues like education, productive employment, housing equity, freedom and dignity, human welfare etc. have emerged as major objectives in development strategies. Since health is an integral part of development, all sectors of society have an effect on health. In other words, health services are no longer considered merely as a complex of solely medical measures but a "subsystem" of an overall socio-economic system. In the final analysis, human health and well-being are the ultimate goal of development.

The International Conference on Population and Development (ICPD) held in Cairo in 1994 marked a major paradigm shift in the conceptualization on reproductive health and on issues related to population and development. The reproductive and child health approach that emerged as from the 1994 ICPD provided a framework for each country to evolve their population policy. Although India was the first country to adopt a family planning program in 1952, it is still growing by 15.5 million people each year. In this respect, the Ministry of Health released the National Population Policy 2000 in February 2001. The policy aims to reduce the total fertility rate to replacement level by 2010 and to achieve a stable population by 2045, at a level consistent with sustainable economic growth, social development, and environmental protection. Among the goals of the policy are keeping the girls in school longer,

raising the marriage age of girls, reducing infant and maternal mortality, and achieving universal immunization of children against vaccine-preventable disease. However, the foremost goals are addressing the unmet needs for reproductive and child health services, supplies and infrastructure. Recognizing the fact that Indian women do not generally decide their reproductive behavior, the proposed policy would focus on information and education campaigns on men to promote small families and to raise awareness of the benefits of birth spacing, better health and nutrition, and better education. Women's health has improved all around the world during the past four decades. A growing number of women now have access to education, and use contraception to have smaller families. All of these developments contribute to better reproductive health (Garg;1997). However, a large number of women still die each year due to reproductive health related and largely preventable causes.

WHO defines reproductive health as people having the ability to reproduce, to regulate fertility, and to practice and enjoy sexual relationships. It also means safe pregnancy, child-birth, contraceptives, and sex. Procreation should include a successful outcome as indicated by infant and child survival, growth, and healthy development. The right to reproductive health is a key component of women's and men's reproductive and sexual rights. Moreover, the achievement of reproductive health is inextricably linked to women's and men's ability to exercise reproductive and sexual rights, which include, besides the right to reproductive health, the right to reproductive decision- making, equality and equity for men and women, and sexual and reproductive security. Reproductive decision-making includes voluntary choice in marriage, family formation and determination of number, timing and spacing of one's children. It also includes the right to have access to the information and means needed to exercise voluntary choice. Equality and equity for men and women means enabling individuals to make free and informed choices in all spheres of their life, free from discrimination based on gender. Sexual and reproductive security includes freedom from sexual violence and coercion, and the right to privacy.

The ICPD Program of Action also identifies the empowerment of women as central to the achievement of reproductive health. Reproductive health as outlined in the ICPD program of Action, and widely recognized thereafter, is a lifetime concern

for both women and men. It is not confined to women of childbearing age. Actually, the WHO initiative on women's health began over two decades ago with a focus on maternal health and family planning. With new knowledge and deeper understanding of women's health problems, the vision has widened to view women's health issues more holistically, through a life span approach, emphasizing the health needs and concerns of women at every stage and in every aspect of their lives- from conception to old age. WHO's focus on women's health and its multiple determinants now includes a gender dimension intensified through collaboration with various WHO technical areas for gender mainstreaming in all health programs. A gender perspective reflects a world-view of health as more than a medical issue confined to biological factors amenable to medical intervention. It also addresses differences between men's and women's health arising from the unequal power relationship between the sexes. How we live, what we do, who we interact with, and the nature of these interactions and relationships – all affect our health. Thus, health is a product of the physical and social environments in which we live and act, which are in turn affected by the global and local environment: social, cultural, economic and political. Inequalities in health across population groups arise largely as a consequence of difference in social and economic status, and differential access to power and resources. The heaviest burden of ill-health is borne by those who are most deprived, not just economically, but also in terms of capabilities, such as literacy and access to resources.

Biological differences between the sexes give rise to differing health needs for men and women. However, biological differences are not the only determinants. Substantial evidence exists to indicate that in almost all societies, women and men have differing roles and responsibilities within the family and in society, different social realities, and unequal access to and control over resources. Differentials in health status between men and women have therefore to be understood within the context of social as well as biological differences. The sexual division of labour within the household, and labour market segregation by sex into predominantly “male” and “female” jobs, expose men and women to varying health risks. In addition, women often have multiple roles in the family and in society, as workers, mothers, and members of their communities. Social values and attitudes which defines men's and women's roles within the family and in the community, and norms

governing acceptable behaviour for men and women, give rise to differentials in access to resources and health care. For example, son preference may influence the investment in health care of boys and girls. Because of the socialization of men and women to adhere to prevailing gender norms, their perceptions and definitions of health and ill-health are likely to vary, as is their health-seeking behaviour. Finally, gender differentials in access to and to control over resources, such as money, transport and time, and differences in men's and women's decision-making power within the family, affect women's access to health services. Women may be allowed to decide on seeking medical care for their children, but may need the permission of their husbands or significant elders within the family to seek health care for themselves. Restrictions on women's physical mobility also make it imperative for women to be accompanied to a health facility by a male family member.

At the 1994 International Conference on Population and Development (ICPD) in Cairo, the world community effectively wrote a new agenda for population and development to serve as the blueprint for population programs internationally and nationally for the next twenty years. ICPD placed the population problem squarely within the development context focusing particularly on quality of life, human rights and women empowerment. At Cairo, the nations of the world agreed that governments should give special attention to the health of women, the survival of infants and young children, the education of girls, and in general, the empowerment of women. At the same time they should provide comprehensive reproductive health services to enable couples to achieve their reproductive goals, and determine freely and responsibly the number and spacing of their children. The ICPD consensus implies that if governments ensure that this basic package of social policies and reproductive health services is in place they will simultaneously make strides toward greater social equity and reducing high rates of population growth (Sinding and Fathalla 1995:18-21). Consensus on the ICPD Program of Action provides the foundation for practical progress towards a number of interrelated sustainable development objectives. However, to achieve these objectives, many unmet needs must be addressed. Several of these can be effectively met only if : A) population agencies move beyond family planning as their main program mechanism and collaborate much more closely with health and development agencies; B) development sectors integrate population-related and human rights concerns into their

policies and programs; C) communities and governments come to terms with imbalances in power and opportunities between the state and its people, between providers and users of services, and between men and women; and D) governments foster participatory processes that give leadership and responsibilities to communities, non-government organizations(NGOs), and the larger civil society.

While the global acknowledgement of reproductive and sexual health has brought much satisfaction and a sense of achievement to many who worked for well over a decade to help develop the new paradigm articulated at ICPD, it has also thrown up fresh challenges. A major challenge confronting governments now is how to translate reproductive and sexual health concepts into policies and programs within national contexts. To translate reproductive rhetoric into reality, two priority issues must be addressed. First, it is essential to make a conceptual shift. Second, packages of good quality services must be designed and implemented to address reproductive and sexual health needs of clients. Clients have multiple needs, many of which are unmet, especially in South Asia, a particularly deprived region. An important priority is to design programs that are truly responsive to the needs of the clients. With a share of 22 percent of the world's people, South Asia is inhabited by 40 percent of the world's absolute poor and is now the poorest region of the world. About one-half of the world's illiterate people live in South Asia. Neglect of basic social services is related to poverty in South Asia. Nearly two-thirds of the population in South Asia is deprived of basic human capabilities, compared to just over one-quarter which is deprived of a minimum income. The impact of deprivation is greatest on women and children. The maternal mortality rate in South Asia is about 600 per 100,000 live births. It is as high as 850 in Bangladesh, 1,500 in Nepal, and 1,600 in Bhutan. These are among the highest maternal mortality rates in the world, when compared to a rate of only 28 in industrial countries. Despite its much higher GNP growth rate and its most robust increase in food production, South Asia has more malnourished children than Sub-Saharan Africa. Almost two-thirds of children in South Asia are underweight, compared to one-sixth in Sub-Saharan Africa. Approximately one-third of all babies in India and one-half in Bangladesh are born with low birth weight. In Sub-Saharan Africa, the proportion is about one-sixth(UNICEF 1996). Traditionally, the concept of unmet need originates from the field of family planning where it has been extensively used to measure the proportion of women/couples who want to limit

and/or space their births but are not using any form of contraception. Because family planning is now seen as an integral part of reproductive and sexual health, this concept of unmet need must be redefined. In a recent essay, Ruth Dixon-Mueller and Adrienne Germain define a broader scope of unmet need. They argue that the concept of unmet need should include: A) recognizing the need among non-users at risk of unwanted pregnancy for any method of contraception; B) the need among some users for a more effective, satisfactory, or safer method; C) the need among both users and non-users for treatment of contraceptive failure (non-use) through and accessible abortion services; and D) the need for related reproductive health services such as the prevention and treatment of reproductive tract infections (RTIs) (Germain and Dixon-Mueller 1992: 33-335).

In order to operationalize reproductive health programs, a change in focus from a population control approach of reducing numbers to a reproductive health approach of addressing the needs of clients is necessary. Implementing reproductive health services within national programs in South Asian countries may require an ideological shift. In India, for example, it would necessitate a change in the culture of the program which has focused in the past on achieving targets to one that will now aim at providing a range of good quality services. The implication is that reproductive health programs should be responsible for reducing the burden of unplanned and unwanted child bearing and related morbidity and mortality (Jain and Bruce 1994: 192-211). Achieving the demographic goal of reducing the rate of population growth requires broader social and economic macro-level policies such as policies to improve education and enhance employment opportunities for women. While reproductive health needs are beginning to be defined, those related to reproductive rights have barely begun to be even articulated in South Asia and are, therefore, largely unmet. The proponents of the reproductive health framework believe that reproductive health is inextricably linked to the subject of reproductive rights and freedom, and to women's status and empowerment. Thus, the reproductive health approach extends beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during the various stages of the life-cycle. In addressing the needs of women and men, such an approach places an emphasis on developing programs that enable clients to: a) make informed reproductive choices and exercise their right to choose; b) receive education and counseling services for

responsible and healthy sexuality; c) obtain services for the prevention of unwanted pregnancy, safe abortion, maternity care and child survival, and for the prevention and management of reproductive morbidity including gynaecological problems, reproductive tract infections(RTIs), sexually transmitted infections(STIs) and HIV/AIDS.

Thus, reproductive and sexual health programs are concerned with a set of specific health problems, identifiable clusters of client groups, and distinctive goals and strategies. This evolving paradigm is being put to its most critical test in South Asia, which is fast emerging as the poorest, the most illiterate, the most malnourished, the least gender sensitive- indeed, the most deprived region in the world (Haq ul 1997). A recent assessment of human development in South Asia, including India, Bangladesh, Nepal, Sri Lanka, Bhutan, and Maldives, showed that while these seven countries share many common characteristics, their performance in raising the level of human development is variable. There has been some progress in the field of health in South Asia. Infant mortality has been cut in half in the last three decades and life expectancy has increased by 17 years, from 44 in 1960 to 61 in 1993. But, there are serious gaps in the field of education. More than one-half of the population in South Asia is still illiterate. Human deprivation is especially grim for women. Two-thirds of adult women in the region are illiterate and maternal mortality is among the highest in the world. A comparison of South Asia's performance with that of East Asia is revealing. Starting with similar income levels three decades ago, East Asia is now way ahead of South Asia in its social and health indicators. It is clear that South Asia has failed to provide adequate coverage of basic social services to its 1.2 billion people (Haq ul 1997). Although a sub-continent, there are significant differentials among the countries of South Asia. At one end of the spectrum is Sri Lanka- its human development and health indicators are among the highest in the world, often surpassing those of many developed countries. Its adult literacy, for example, is 90 percent. Population growth rate is 1.5 percent, compared to an average of 2.3 percent for South Asia. Its life expectancy at 72 is 11 years longer than the South Asian average of 61 years. Infant mortality in Sri Lanka is 15 per 1000 live births compared to 91 in Bangladesh, 95 in Pakistan, and 79 in India. Basic health facilities are available to 93 percent of Sri Lanka's population (Haq ul 1997). In contrast, other South Asian countries, such Pakistan, India, and Bangladesh depict gloomy socio-

demographic and health profiles including a huge unmet need in these countries. The reproductive Risk Index designed by Population Action International ranks India and Sri Lanka in the moderate risk category, and Bangladesh, Nepal, and Pakistan in the high risk group (Population Action International 1995). Addressing unmet needs implies designing strategies to target neglected client groups such as women, men and adolescents as well as implementing services to meet their priority reproductive and sexual health needs throughout the life-cycle. If reproductive health programs are designed to address client's needs, the quality of service must be improved, particularly as perceived by clients. There is a need to focus on women since they constitute the major client group or users of these programs and also have the greatest problem of access, both physical and social, to health services (Pachauri 1994). There are ample data worldwide showing a high burden of reproductive morbidity among women in developing countries. According to the World Bank, about one-third of the total disease burden in developing countries among women in the age group of 15 to 44 years is linked to health problems related to pregnancy, childbirth, abortion, human immuno-deficiency virus (HIV), and RTIs (World Bank 1993). Available data for South Asia show that women have a huge unmet need for services related to these conditions. Socio-economic and biological determinants operate synergistically throughout the lives of poor women in South Asia to undermine their health, resulting in high levels of morbidity and mortality (Gittlesohn et al. 1994; Akhtar, Rahman and Ahmed 1996). However, among diseases for which cost-effective interventions exist, reproductive health problems account for the majority of the disease burden in women of this age group. There is therefore, an urgent need to design and implement cost-effective programs to address women's reproductive health needs. Women-centered, gender-sensitive services must be organized and implemented(Pachauri 1995). Since gender inequalities favor men in South Asian countries and sexual and reproductive health decisions are largely made by men, there is a growing realization that unless men are reached, program efforts will have limited impact. Research on sexuality, especially in the field of HIV/AIDS, has highlighted the inadequacy of strategies that target only women. Because of the prevailing gender-power equation, women are not only especially vulnerable, but are also unable to negotiate changes in sexual behaviour. Research on sexual negotiation has dramatically underscored the need for involving men in programs that aim at bringing about changes in sexual behaviour for the prevention of infection. However, such behavioural change is relevant not only for

the prevention of infection but also for addressing other reproductive and sexual health problems. Reproductive and sexual health needs of men have not been addressed by past programs that have mainly targeted women. Men too have unmet needs as illustrated by recent work in India(Khan, Khan and Mukherjee 1997:18-30) and Bangladesh(Hawk 1997). Therefore, the involvement of men as partners is essential (Pachauri 1996). Adolescents are another neglected client group. Adolescents have been by-passed by all programs and consequently their needs have neither been assessed nor addressed. Health services for the adolescent girl have special significance in South Asian countries where there is a son preference. Such services would not only affect the health of the adolescent girl but would also have long-term inter-generational effects by reducing the risk of low birth weight and minimizing subsequent child mortality risks. So far, neither services nor research have focused on the adolescent's health and information needs. Youth 10-24 years of age represent about a third of the population in the countries of South Asia (Population Reference Bureau 1996). Therefore, the consequences of this neglect takes on enormous proportions, particularly as adolescents are exposed to the rising threat of HIV and STIs (Pachauri 1995). Data on the magnitude of reproductive and sexual health morbidity in South Asia are sparse. Research is urgently needed to systematically assess the extent of reproductive and sexual health problems in the countries of the region so that program priorities can be delineated. The magnitude of women's reproductive health problems is reflected in the number of deaths related to pregnancy and childbirth, the most direct indicator of reproductive health care. Worldwide, there are half a million deaths of women each year related to pregnancy and all but 6,000 of these occur in the developing world. Maternal mortality is notoriously difficult to measure accurately and so only estimates are available. India's maternal mortality ratio, 400-500 per 100,000 live births, is fifty times higher than that of many developed countries and six times higher than that of Sri Lanka (Ascadi and Johnson-Ascadi 1990). The maternal mortality ratio is estimated at 450 in Bangladesh (Ascadi and Johnson-Ascadi 1990) and at 1,500 in Nepal per 100,000 live births(United Nations 1995). Mortality statistics, however, tell us only a part of the story. For every woman who dies, many more suffer serious illness. Community-based data on maternal morbidity are scarce. In recent studies, for every maternal death there were 643 morbidities in Bangladesh and 541 in India (Fortney and Jason(eds)1996). In Bangladesh and India, 80 and 58 percent women respectively,

reported at least one morbidity during pregnancy and the puerperium; 24 and 2 percent respectively, reported five or more morbidities. A life-threatening morbidity was reported by 5 percent of Indian women and 32 percent of Bangladeshi Women. Life-threatening and serious morbidities were reported by 46 percent of Indian and 65 percent Bangladeshi women. For every woman who died from pregnancy-related causes, 65 percent women in Bangladesh and 25 percent in India suffered from chronic morbidity (Fortney and Jason (eds) 1996). These data on maternal mortality and morbidity underscore the high level of unmet need for maternal care among women in South Asian countries. By some estimates, better care during labor and delivery could prevent 50-80 percent maternal deaths (Rodriguez et al. 1985; Walker et al.1986:486-488). But, the best majority of births in India, Bangladesh, and Pakistan take place at home and, are handled mostly by untrained birth attendants. As recently as 1992-1993, no more than 16 percent of all rural births in India were conducted in institutions and as many as two-thirds were delivered by traditional birth attendants (International Institute of Population Studies 1994). In Sri Lanka, however, trained personnel attend 94 percent of the births (United Nations 1995). Malnutrition is an underlying problem that seriously affects the health of adolescent girls and adult women and has its roots in early childhood. About 85 percent women in South Asia are anemic, the association between anemia and low birth weight, prematurity, perinatal mortality and maternal mortality has been extensively documented in South Asian countries. An area that has not been explored relates to violence and injuries which accounted for 14 percent of maternal deaths in Bangladesh (Rahman, Whittaker and Hossain 1991). Recent research shows that gender violence is pervasive in South Asian countries (Sidney, Hashemi and Riley 1997; Sood(ed) 1990; Deraniyagala 1990). This problem, however, remains invisible because of the silence that shrouds it. It is a problem that is denied by society. Unsafe induced abortion is the greatest single cause of mortality, and at the same time, the most preventable one. Of all the major causes of maternal deaths, those that lead to abortion deaths are better understood. Women do not need to die or suffer medical consequences from abortions because abortions do not necessarily kill; it is carelessly performed abortions which kill (Main 1991). Abortion is illegal in most South Asian countries. In India abortion was legalized over 20 years ago, but is still a neglected problem. Access to safe abortion services for poor women, especially in rural areas, remains problematic in India. The conceptual link between family planning and abortion is fundamental.

Effective contraception is an important means of preventing unwanted pregnancy thus pre-empting the need for abortion. In the absence of safe contraceptive backup, however, women will be continued to be forced to employ unsafe means for terminating unwanted pregnancies with attending high maternal mortality and morbidity. Data on abortion are unreliable and difficult to obtain. According to official estimates 1.5 million abortions occur in South Asia each year. The estimated abortion rates per 1000 women of reproductive age are 3.4 in Bangladesh, 3.0 in India, 4.1 in Nepal, and 5.4 in Sri Lanka (International Planned Parenthood Federation South Asia Region 19994). These figures are likely to be significant underestimates because abortion is illegal and/or severely restricted in all South Asian countries except India. Therefore, the majority of abortions in the region are clandestine; are usually performed under unsafe conditions; and are not reported (Kapoor 1997). Since community-based research on women's reproductive illnesses, including RTIs and STIs, was neglected in the past, these problems remained invisible (Bang and Bang 1991:27-30). Rani Bang's landmark study in a rural, tribal area of Maharashtra, India, indicating that 92 percent of the women suffered from one or more gynaecological problems and that the majority had never sought any treatment, created quite a stir nationally and internationally. This study not only depicted the magnitude of the problem of gynaecological morbidity in poor women, but also brought into focus the neglected associated with these problems (Bang et al. 1989:85-88). It highlighted the need for further research to assess levels of morbidity among poor women. A recent review of nine community-based studies of gynaecological morbidity in India showed a considerable burden of RTIs/STIs (Koenig et al. 1996). In Maharashtra, the prevalence of infections including vaginitis, cervicitis, and pelvic inflammatory disease(PID) was 46 percent(Bang et al. 1989 :85-88). In four community-based studies of gynaecological morbidity recently conducted in four different sites in India (rural West Bengal and Gujarat, and urban Baroda and Bombay), the prevalence of clinically diagnosed RTIs ranged from 19 to 71 percent (Baroda Citizen's Council). In a similar study conducted in rural Karnataka, over 70 percent of women had clinical or laboratory evidence of RTIs (Bhatia et al.1997:95-103). These studies leave little doubt that prevalence of RTIs in India is unacceptably high and that gynaecological morbidity constitutes a major public health problem among poor women. Research in India shows that poor women carry a heavy burden of reproductive morbidity; a significant component of such morbidity is unrelated to pregnancy and is due to RTIs,

many of which are sexually transmitted; these reproductive problems are invisible because of socio-cultural reasons and are unattended because women do not have access to health care for these illnesses (Pachauri 1994). Studies in Bangladesh also show a significant burden of reproductive morbidity. In a survey of a rural community, where the magnitude and nature of morbidity due to RTIs among users and non-users of contraceptives was assessed, 22 percent of the 2,929 women surveyed reported symptoms of infection. Of the 472 symptomatic women examined, 68 percent had clinical or laboratory evidence of infection (Wasserheit et al. 1989: 69-79). Thus, there is growing evidence that the burden of reproductive morbidity is unacceptably high among poor women in South Asia. This represents an important unmet need because these RTIs are frequently asymptomatic in women and are not recognized and treated. Certain contraceptive methods increase the risk of RTIs. For example, oral contraceptives predispose women to candidiasis and Chlamydia infection (Wasserheit et al.1989:69-79). These linkages between RTIs and contraception further complicate the problem, adding yet another dimension to the already complex challenge of addressing these problems. Poor women are also at increased risk of RTIs because of the unhygienic management of menstruation. Childbirth and abortion exacerbate infections of the lower reproductive tract and facilitate their spread to the upper tract. Untreated lower tract infections are likely to progress to pelvic inflammatory disease which has serious sequelae including infertility, ectopic pregnancy, chronic pain, and recurrent infection. The problem of infertility is particularly serious and can be devastating for women in South Asia where child bearing is highly valued. RTIs and STIs, poor obstetric and gynaecological practices, illegal abortions and post partum and post abortion infections are all preventable causes of infertility (Pachauri 1994). In addition, RTIs effect fetal wastage, low birth weight and congenital infection, and thereby, impact on pregnancy outcome, child health and survival. The treatment of these infections is, therefore, a cost-effective approach to reduce perinatal and neonatal mortality. Child survival programs currently underway in South Asia are not designed to address these problems (Pachauri 1994). So far, cancers of the reproductive tract have received little attention even though these increasingly contribute to reproductive morbidity in South Asia. There is an established association between RTIs and cervical cancer (Mishra and Sinha 1990:21; Indian Council of Medical Research 1990; Murthy, Sehgal and Satyanarayana 1990: 732-736). Early onset of sexual activity and multiple sexual

partners increase the risk of cervical cancer (Menon et al. 1988: 2-4). The high incidence of cervicitis that is not due to conventional STI pathogens, has been postulated as a possible risk factor for cervical cancer among Indian Women (Luthra et al. 1992). Cervical screenings is an important means for preventing cancer but at present only limited screening facilities are available to women in South Asia. For example, while 15 percent of the world's cervical cancer cases exist in India, screening facilities are available only to a small minority of urban women. By the turn of the century, Asia is expected to become the epicenter of the global HIV/AIDS pandemic. Denial of the problem in south Asia continues to impede action. This represents a huge unmet need for South Asia. After the first AIDS case was reported in India in May 1986, some 6,154 cases have been reported (National AIDS Control Organization 1998). These reported figures are believed to be a gross underestimate. Over the years, there has been a steep rise in the reported seropositivity rate- from 2.5 per 1000 in 1986 to 20 per 1000 in 1998 (National AIDS Control Organization 1997). The prevalence of HIV infection has been on the rise in practically all states and all population groups in India. The increase is observed irrespective of when the infection reached a state. The north-eastern region of India is experiencing a major HIV/AIDS endemic. In this region, infection is spread predominantly by injecting drug users. The state of Manipur which borders Myanmar, accounts for the highest number of cases in this region. After its initial detection in 1989, the prevalence of HIV among intravenous drug users in Manipur increased sharply. It was 64 percent by 1993 (Sarkar et al. 1993: 23-28). Manipur state borders the 'Golden Triangle' of Myanmar, Laos and Thailand and is on the drug trading route. There is an explosive HIV/AIDS epidemic among drug users in Myanmar where over 60 percent of the world's opiates are produced. There is a growing realization that horizontal integration of services must be achieved if reproductive and sexual health and rights are to be universally realized. There must be a convergence of services at the users level as the user or client has multiple reproductive health needs and often the same providers deliver services that are administered through multiple vertical programs. Vertical programs that originate from different government departments and are funded by multiple donors, each with its own agenda, can result in a multiplicity and fragmentation of services which can be wasteful and inefficient. Thus far, most reproductive health programs are provided through vertical systems. Services for promoting family planning, improving child survival, and preventing HIV/AIDS are

particular examples. It would be counterproductive to have reproductive health as yet another vertical program. In fact, the reproductive health approach provides an opportunity for integrating services. A critical mass of resources could also achieve greater cost-effectiveness. In South Asian countries, governments have implemented family planning programs for the past three to four decades. Child survival programs have been implemented since the 1980s. Services for promoting safe motherhood have been put in place more recently. Prevention of HIV/AIDS and STIs are also more recent initiatives. The challenge is to strengthen all these services by expanding their reach, improving their quality and effectively integrating additional reproductive health services within ongoing programs.

Women bear the greatest burden of human deprivation in South Asia. The Gender-related Development Index (GDI), which adjusts the measure of average human development to take account of gender disparities, shows a value of only 0.41 for South Asia, which is 25 percent lower than the average for developing countries and less than half that of the industrial world. However, access to political, economic, and social opportunities, which is reflected by the Gender Empowerment Measure (GEM), starkly indicates deprivation among South Asian women. South Asia's GEM index of 0.23, is the lowest among all regions of the world, including Sub-Saharan Africa (Haq ul 1997). For the most part, the neglect of women is related to low status and lack of autonomy. There is an overwhelming son preference in South Asian societies. South Asia is the only region in the world where men outnumber women. While Sri Lanka and Maldives have nearly equal male-female populations, the ratio of females for every 100 males is 96 in Nepal, 93 in Pakistan, 94 in India (Haq ul 1997). Some 74 million women are simply missing in South Asia. Women's voices have yet to be heard by the vanguards of the society.

Women, in general, have to play a dual role in the society. Though the 'home-making' role of women is not given much importance. A woman working outside for livelihood is also has to play her domestic role. Still, in matters related to decision-making, women play a silent role. Even, in matters related to her health she has to take permission of a male member or an elderly person before going to take any decision. Women's decision-making typically is affected by three levels of her interaction. The farthest is the external environment which provides her the services.

She is a part of the society. This society has its own culture which governs the concept of health-seeking behaviour. This cultural environment, which has a daily interaction in her life, affects her in ways more than one. First, these norms go on to shape ways which she is expected to follow unquestioningly. Second, these norms, on account of awareness, become strong beliefs and stay as stigmas until the veil of ignorance is diminished. Ignorance or lack of proper knowledge influences the women's perceptions and affects her knowledge about dos and don'ts of reproductive health and her health in total. Education is one of the governing agents in shaping the perception of women or society at large, but this again depends on the accessibility and availability of educational institutions like schools, colleges etc. Women's position in the family and society in countries of the South East Asia presents a complex picture of modernity and tradition, and of strivings for gender equity amidst pressures to maintain the status quo. On the one hand, there is evidence of women's growing awareness and assertiveness of their rights, educational advancement, and increased participation in the economy and in the public arena. At the same time, there is continuing domination of patriarchal values and traditions reflected in son preference, seclusion of women among some populations, and restriction of their mobility among others. Laws that restrict women's inheritance and make them unequal partners in marriage infringe on women's sexual and reproductive rights. All these have serious negative consequences on women's health and quality of life. Biological and social reproductions form the foundation of human society. In almost all societies around the world, in addition to child-bearing, responsibilities for social reproduction – the care of the family, the maintenance of the household, the processing and cooking of food and related tasks – fall to women. These tasks are arduous and time consuming, especially in societies and among social classes that do not have the benefit of labour-saving technologies. In rural and shanty town areas, fetching water is among the most strenuous tasks carried out by women. The ILO recommends a maximum load of 25-30 kilograms for women, but this is often exceeded. Carrying as much as 40-50 kilograms on the head, shoulders and hips requires muscular strength and skill. Women carrying water have to slant their body in order to balance the weight and have to walk in this posture for long distances. Over a period of time, postural defects of the neck, spine and pelvis may develop. Women are also at risk of accidents leading to fractures, slipped discs and paralysis. Similar problem arise when carrying heavy loads of fire wood or baskets of dung or

other agricultural waste for cooking fuel. Fetching fuel and fodder also exposes women to the risk of injuries by sharp objects. Deforestation and the depletion of natural resources, discussed earlier, have added considerably to women's daily workload, both in terms of distances to be traversed and loads to be carried each time. Strenuous work of this nature or accidents while performing these tasks may result in miscarriages and other reproductive health problems. In a recent study from Tamil Nadu, India, of women who were agricultural wage workers from poor households, carrying heavy objects soon after delivery was the single most common factor associated with the prevalence of second or third degree uterine prolapse, irrespective of age and parity. Cooking stoves in many poor South-East Asian households are not at an appropriate height but are at ground level. Women normally cook in a squatted position close to the fire. Minor and major burns from cooking stoves are a common problem among these women. Further, the combination of thatched roofing which dries up in summer and open fire wood stoves with no possibility of regulating the fire, poses a major fire hazard. No studies, however, are available on the proportion of burn injuries in women caused while cooking. Women are exposed to vector-borne diseases, skin infections, worm infections and infectious diseases caused by poor personal hygiene while handling waste. The toxicity of commonly used household cleaning agents also affects women disproportionately. Having to provide food for the family in seasons of scarcity can be a major source of stress to women. In Bangladesh, nearly 77 percent of the populations who live in rural areas are affected by a scarcity of food during the pre-harvest period between August and November. A higher incidence of malnutrition is found during this period, mostly affecting women and children. It is often believed that child care is more of an issue for urban middle-class women working to supplement the family income. This is a far cry from the reality. Child care is an important issue for poor women, both urban and rural, and lack of appropriate facilities limits women's access to economically remunerative work outside the home, forcing them into home-based or other flexible jobs which are often poorly paid. If such work is not available, the women has to take the child with her to work, or keep an older girl child at home to take care of the younger siblings. In a study by SEWA in Ahmedabad, India, on the impact of its child care support activities for low-income working mothers, many women reported that child care facilities had made it possible for them to seek waged work. As a result, there had been an increase in the monthly income of the household. In urban Bangladesh,

women who work in factories have to stay outside the home for long hours. They are unable to breast-feed their children and have to entrust care of their young children to persons who are not suitable, even to other children of 7-10 years of age. This is a source of considerable tension and stress. Poor child care can result in children suffering frequent infections, adding further to the stress suffered by the working woman. Women's involvement in productive and reproductive work results in a stress-filled double workday of long hours. This is evident from the Indian studies, showing that women worked 55 hours a week as against the 47 hours worked by men, and that women's work involved a greater expenditure of energy. A study in Nepal conducted in 1993 by Stri Shakti, a women's nongovernmental organization, also showed that rural women worked for an average of 10.3 hours per day, while men worked for an average of 7.9 hours per day. In northeastern Thailand, women spend on average 11-15 hours a day for household chores, not including time spend for child care which runs concurrently with their other chores. Another study found that women in rural areas spent an average of 1644 hours per year working in agricultural production, compared to 2294 hours for men. But women's domestic burdens were seen as "light" and "boring", as well as being solely women's responsibility. Long hours of work which are beyond their control, guilt over constant family demands, the struggle to perform both jobs reasonably well, dissatisfaction with their performance and self-blame for failures are all aspects of the double workday familiar to many working women. The pathologies which can be associated with the double workday include irritability, headache, fatigue, anguish, fear and depression. In addition, other symptoms appear without apparent explanation: colitis, gastritis, hypertension, migraines and neuroses.

The important biological differences by sex which put women and men at differential risks from environmental factors have often been recognized when examining environmental health issues. When compared to men, women have a smaller stature, their vital capacity is 11 percent less, and their haemoglobin is approximately 20 percent less. They have a larger skin surface area when compared to circulating volume, and more fat content in their bodies. Moreover, women's role in biological reproduction exposes them as well as their unborn children to additional health risks. However, this constitutes only one part of a gendered understanding of environmental health issues. In almost all societies, women and men tend to occupy,

use and manage aspects of the biophysical environment in a gender differentiated manner. Women and men engage in different spheres of activity, and the amount of time they spend interacting with various elements of the environment tend to vary. It may therefore be anticipated that the nature and degree of the environmental health risks to which women and men are exposed would be different. Despite this, few studies have examined environmental risks and health consequences from such a perspective. Environmental health hazards include traditional hazards arising from human activity and natural phenomena, such as poor sanitation and contaminated drinking water, and indoor air pollution. They also include modern hazards, such as outdoor air pollution, water pollution from industrial effluents and the lowering of the water table, chemical and radiation hazards, and depletion of natural resources that have resulted from the pattern of economic development adopted by most countries.

Violence against women considerably increases women's risk of poor health. The World Bank (1993) estimates that rape and domestic violence account for 5 percent of the healthy years of life lost to women aged 15-44 years in developing countries. The global health burden from violence against women in the reproductive age group is about 9.5 million disability-adjusted life years (DALYs), comparable to risk factors such as tuberculosis (10.9 million DALYs), HIV (10.0 million DALYs). Violence suffered by women can have fatal outcomes, including suicide and homicide. The seriousness of physical assault on women is evident from the two studies stated below, which examined deaths from violence. One of these is a study from Bangladesh examining 270 cases of deaths related to abuse reported in newspapers during 1982-1985. Twenty-nine percent of the women had been beaten to death, thirty-nine percent subjected to other forms of physical torture, and eighteen percent had been attacked with sharp weapons. The second study, from court records in Maharashtra, India, covered 120 cases of dowry deaths of women (homicides committed by the husband or his family members ostensibly because their demands for dowry were not met). The women were very young – eighty-eight percent were below 25 years. Forty-six percent of these women had died of burns and thirty-four percent had died of drowning. The principal accused was the husband in eighty-six percent of the 120 cases of homicide. The association of suicides with gender-based violence is more difficult to establish. Three studies from India which document causes of suicide in women find that marital discord is an important precipitating

factor. A one-year study of suicides in Delhi, India revealed that 56 percent of the suicide cases were women. Marital discord and ill treatment by the husband and in-laws were the most common reported causes. Two other studies from Chennai (Madras) and Daspur in India, reported that the peak age for suicide was between 15 and 24 years, and the most commonly cited reason was quarrel or maladjustment with the husband. Accidents and injuries, including self-inflicted injury and intentional injury by others, are an important cause of mortality in both women and men all over the world. Countries of the South-East Asia Region are no exception. For example, in Sri Lanka, suicides and self-inflicted injuries ranked sixth among the leading causes of death in women. It would be worthwhile probing into the association between gender-based violence and deaths of women from intentional injury perpetrated by others, as well as suicides and self-inflicted injury. Gender violence can also cause maternal deaths. The Nepal maternal mortality and morbidity study reported that 4 of 132 maternal deaths were suicides. Almost 16 percent of deaths in pregnancy were caused by domestic violence according to a community and hospital based prospective study in Maharashtra, India, conducted during 1993-1995. An earlier study from Bangladesh of 387 maternal deaths in Matlab during 1976-85 had also found that 9 percent of the deaths were caused by injuries and violence. A third of these deaths were suicides and 25 percents were homicides. 34 percent of the women reporting abuse by their husbands in southern India needed medical attention. Victims of acid-throwing in Bangladesh and of burns in India, if they survive the attack, are left permanently disfigured. Attack with sharp weapons is also frequently mentioned. Violence against a pregnant woman may also result in miscarriage or perinatal death. Studies have found strong associations between pelvic pain in women and violence by their male partners. Other problems include lack of libido and sexual dysfunction. Experiences from Latin America show that, for many women, the sex of their newborn baby will determine the improvement or deterioration of their current conjugal relationship. Initiation of obligatory sexual relations soon after delivery is another form of violence experienced by women. The possibility that this could result in another pregnancy could be a major source of anxiety. Sexual abuse, including forced intercourse, within marriage and refusal to use condoms, puts women at risk of unwanted pregnancy, HIV/AIDS and other STIs. This is not only in the case of sexual assault or rape. Studies from other Regions have shown, for example, that women's bargaining power in marriage was lowest with regard to decisions about whether and

when to have sexual intercourse. The threat of violence by the male partner may make women accede to nonconsensual sex and make it difficult to negotiate for condom use. Fear of male reprisal is also often a barrier to the use of family planning by women. Women's wish to use contraception may be viewed by men as signaling their intention to be unfaithful, or as an affront to her partner's masculinity. Not all women who fear violence because of using contraceptives may actually be at risk of abuse by their husbands. Nevertheless, fear of violence may be a major deterrent to women's contraceptive use. Refusal by the husband to give permission for using contraception is often mentioned by women as a reason for non-use of contraception. Unwanted pregnancy can become life-threatening if women seek illegal abortions. Far more difficult to capture than consequences to physical well-being is the damage to women's mental health as a result of exposure to abuse and violence from an intimate male partner. This is not only the case when the woman experiences physical assault. Mental violence may in many instances be more widespread than physical violence and battering. Verbal abuse, harassment and the deprivation of women of physical and financial resources create fear and undermine the security and self-confidence of women, diminish their coping capacity, and make them vulnerable to a range of mental disorders. Depression, anxiety, fear, and sleeping and eating disturbances are common long-term reactions to violence, while after an episode of sexual or physical abuse, the clinical picture is similar to that of posttraumatic stress disorder (PTSD). The psychological dysfunction associated with experiencing violence may also have fatal consequences by including suicidal behaviour. Sexual abuse and rape are physical and psychological violations of an entirely different genre from other kinds of violence. They can cause both physical injury and profound emotional trauma. A study of rape in urban and rural areas of Bangladesh reported that 84 percent of the victims suffered severe injuries, unconsciousness, mental illness or death following the rape. Survivors of sexual assault are known to suffer a variety of trauma-induced symptoms and severe sexual problems. According to one study from the USA, women who had been sexually assaulted were about two times more likely to qualify for ten different psychiatric diagnoses, including major depression, alcohol abuse, PTSD, drug abuse, obsessive-compulsive disorder, generalized anxiety, eating disorders, multiple personality disorder, and borderline personality syndrome. Paradoxically, in societies where virginity is highly valued, women victims of sexual assault and rape are often viewed harshly by the community, although rape itself is viewed as evil and

cruel, and as destroying human dignity. Public opinion is often ambivalent, and it is not uncommon that it will incriminate the victim, or hold the victim some way responsible for precipitating the sexual assault. For the survivor of sexual assault, the mental and physical health consequences of such a social attitude can be especially severe.

While the neglect of women is a wide spread phenomenon throughout South Asia, there are some important differences among the countries of the region. Sri Lanka has performed fairly well in investing in and providing opportunities to women. In Sri Lanka, female literacy is 86 percent, female life expectancy is 106 percent of male life expectancy, and the female economic activity rate is 36 percent. Pakistan, on the other hand, ranks lowest in the region in most gender-related human development indicators. Its female literacy rate is only 23 percent; female school enrollment is 16 percent; and female participation in economic activities is only 16 percent (Haq ul 1997). Even though reproductive health rhetoric is now used by many, there are major information gaps at all levels ranging from a lack of understanding of the reproductive health and rights concepts to questions about what short-term and long-term strategies are needed at the policy and program levels to implement services. This lack of information presents a major deterrent to implementing programs to address unmet reproductive and sexual health needs in South Asia. Strong advocacy is needed to translate the rhetoric into reality. A range of different constituencies, including governments, donors, NGOs, activists, feminists, and researchers, must be informed and empowered to catalyze a process of networking with a growing number of stakeholders so that the ideology and the ethos embodied in the reproductive health concept is effectively internalized and programs responsive to clients' needs are designed and implemented (Pachauri 1995). The magnitude of unmet reproductive and sexual health needs in South Asia is daunting. The problems in this deprived region are many. However, a changing policy environment presents an opportunity to make a difference. Several countries in the region are making a paradigm shift and are redesigning their national programs to operationalize the ICPD Plan of Action. Reproductive and sexual health programs are now on the agenda of South Asia. India launched a major national Reproductive and Child Health program in October, 1997. Bangladesh is in the process of designing a program. Discussions are underway in other countries of the region to define

reproductive health agendas and to redesign programs responsive to local needs. Translating reproductive rhetoric into reality in South Asia presents a challenge that will require joint action by governments, donors, NGOs, the private sector and the larger civil society. Concerted efforts must be made to provide an enabling environment and to partnerships so that unmet reproductive and sexual health needs of the peoples of South Asia can be addressed by the involvement and participation to all.

Within each community, nationality and class, the burden of hardship often falls disproportionately on women. The afflicted world in which we live is characterized by deeply unequal sharing of the burden of adversities between women and men. Gender inequality exists in most parts of the world, from Japan to Morocco, from Uzbekistan to the United States of America. However, inequality between women and men can take very many different forms. Indeed, gender inequality is not one homogeneous phenomenon, but a collection of disparate and interlinked problems. Some of the important aspects where inequalities are much more prevalent are- A) Mortality inequality, B) Natality equality, C) Basic facility inequality, D) Special opportunity equality, E) Professional inequality, F) Ownership inequality, G) Household inequality.

In some regions in the world, inequality between women and men directly involves matters of life and death, and the brutal form of unusually high mortality rates of women and a consequent preponderance of men in total population as opposed to the preponderance of women found in societies with little or no gender bias in health care and nutrition. Mortality inequality has been observed extensively in North Africa and in Asia, including China and South Asia.

Given a preference for boys over girls that many male-dominated societies have, gender inequality can manifest itself in the form of the parents wanting the newborn to be a boy rather than a girl. There was a time when this could be no more than a wish (a daydream or a nightmare, depending on one's perspective), but with the availability of modern techniques to determine the gender of the fetus, sex selective abortion has become common in many countries. It is particularly prevalent in East Asia, in China and South Korea in particular, but also in Singapore and Taiwan, and it

is beginning to emerge as a statistically significant phenomenon in India south Asia as well. This is high-tech sexism.

Even when demographic characteristics do not show much or any anti-female bias, there are other ways in which women can have less than a square deal. Afghanistan may be the only country in the world the government of which is keen on actively excluding girls from schooling (it combines this with other features of massive gender inequality), but there are many countries in Asia and Africa, and also in Latin America, where girls have far less opportunity of schooling than boys do. There are deficiencies in basic facilities available to women, varying from encouragement to cultivate one's natural talents to fair participation in rewarding social functions of the community.

Even when there is relatively little difference in basic facilities including schooling, the opportunities of higher education may be far fewer for young women than for young men. Indeed, gender bias in higher education and professional training can be observed even in some of the richest countries in the world, in Europe and North America. Sometimes this type of division has been based on the superficially innocuous idea that the respective "provinces" of men and women are just different.

In terms of employment as well as promotion in work and occupation, women often face greater handicap than men. A country like Japan may be quite egalitarian in matters of demography or basic facilities, and even, to a great extent, in higher education, and yet progress to elevated levels of employment and occupation seemed to be much more problematic for women than for men.

In many societies the ownership of property can also be very unequal. Even basic assets such as homes and land may be very asymmetrically shared. The absence of claims to property can not only reduce the voice of women, but also make it harder for women to enter and flourish in commercial, economic and even some social activities. This type of inequality has existed in most parts of the world, though there are also local variations. For example, even though traditional property rights have favoured men in the bulk of India, in what is now the state of Kerala, there has been,

for a long time, matrilineal inheritance for an influential part of the community, namely the Nairs.

There are often enough, basic inequalities in gender relations within the family or the household, which can take many different forms. Even in cases in which there are no overt signs of anti-female bias in, say, survival or son-preference or education, or even in promotion to higher executive positions, the family arrangements can be quite unequal in terms of sharing the burden of housework and child care. It is, for example, quite common in many societies to take it for granted that while men will naturally work outside the home, women could do it if and only if they could combine it with various inescapable and unequally shared household duties. This is sometimes called “division of labour,” though women could be forgiven for seeing it as “accumulation of labour”. The reach of this inequality includes not only unequal relations within the family, but also derivative inequalities in employment and recognition in the outside world. Also, the established fixity of this type of “division” or “accumulation” of labour can also have far-reaching effects on the knowledge and understanding of different types of work in professional circles.

It is important to take note of the variety of forms that gender inequality can take. First, inequality between women and can not be confronted and overcome by any one set of all-purpose remedy. Second, over time the same country can move from one kind of gender inequality to harbouring other forms of that inequality. Third, the different forms of gender inequality can impose diverse adversities on the lives of men and boys, in addition to those of women and girls. In understanding the different aspects of the evil of gender inequality, we have to look beyond the predicament of women and examine the problems created for men as well as by the asymmetric treatment of women. These casual connections, which can be very significant, can vary with the form of gender inequality. Finally, inequalities of different kinds can also, frequently enough, feed each other, and we have to be aware of their inter-linkages. It will not be worth thinking that the United States or Western Europe is free from gender bias simply because some of the empirical generalizations that can be made about the subcontinent would not hold in the West. Given the many faces of gender inequality, much would depend on which face we look at. For example, India, along with Bangladesh, Pakistan and Sri Lanka, has had female heads of

governments, which the United States or Japan has not yet had. Indeed, in the case of Bangladesh, where both the Prime Minister and the Leader of the Opposition are women, one might begin to wonder whether any man could possibly rise to a leadership position there in the near future. Indeed, in the scale of mortality inequality, India – as well as Pakistan and Bangladesh – is close to the bottom of the league in gender disparity. And, it will not be incorrect if we say, natality inequality is also beginning to rear its ugly head very firmly and very fast right at this time in the subcontinent. In the bulk of the subcontinent, with only a few exceptions (such as Sri Lanka and the State of Kerala in India), female mortality rates are very significantly higher than what could be expected given the mortality patterns of men (in the respective age groups). This type of gender inequality need not entail any conscious homicide, and it would be a mistake to try to explain this large phenomenon by invoking the occasional cases of female infanticide that are reported from China or India; these are truly dreadful events when they occur, but they are relatively rare. Rather, the mortality disadvantage of women works mainly through a widespread neglect of health, nutrition and other interests of women that influence survival. It is sometimes presumed that there are more women than men in the world, since that is well-known to be the case in Europe and North America, which have a female to male ratio of 1.05 or so, on the average (that is, about 105 women per 100 men). But women do not outnumber men in the world as a whole; indeed there are only about 98 women per 100 men on the globe. This “shortfall” of women is most acute in Asia and North Africa. For example, the number of females per 100 males in the total population is 97 in Egypt and Iran, 95 in Bangladesh and Turkey, 94 in China, 93 in India and Pakistan, and 84 in Soudi Arabia (though the last ratio is considerably reduced by the presence of male migrant workers from elsewhere who come to Soudi Arabia). It has been widely observed that given similar health care and nutrition, women tend typically to have lower age-specific mortality rates than men do. Indeed, even female fetuses tend to have a lower probability of miscarriage than male fetuses have. Everywhere in the world, more male babies are born than female babies (and an even higher proportion of male fetuses are conceived compared with female fetuses), but throughout their respective lives the proportion of males goes on falling as we move to higher and higher age groups, due to typically greater male mortality rates. The excess of females over males in the population of Europe and North America comes about as a result of this greater survival chance of females in different age

groups. However, in many parts of the world, women receive less attention and health care than men do, and particularly girls often receive very much less support than boys. As a result of this gender bias, the mortality rates of females often exceed those of males in these countries. The concept of “missing women” was devised to give some idea of the enormity of the phenomenon of women’s adversity in mortality by focusing on the women who are simply not there, due to unusually high mortality compared with male mortality rates. This basic idea is to find some rough and ready way to understand the quantitative difference between (1) the actual number of women in these countries, and (2) the number we could expect to see if the gender pattern of mortality were similar in these countries as in other regions of the world that do not have a significant bias against women in terms of health care and other attentions relevant for survival. For example, if we take the ratio of women to men in sub-Saharan Africa as the standard (there is relatively little bias against women in terms of health care, social status and mortality rates in sub-Saharan Africa, even though the absolute numbers are quite dreadful for both men and women), then its female-male ratio of 1.022 can be used to calculate the number of missing women in women-short countries. For example, with India’s female-male ratio of 0.93, there is a total difference of 9 percent (of the male population) between that ratio and the standard used for comparison, namely, the sub-Saharan African ratio of 1.022. This yielded a figure of 37 million missing women already in 1986. Using the same sub-Saharan standard, China had 44 million missing women, and it was evident that for the world as a whole the magnitude of shortfall easily exceeded 100 million. Other standards and different procedures can also be used, as has been done by Ansley Coale and Stephen Klasen, getting somewhat different numbers, but invariably very large ones (Klasen’s total number is about 80 million missing women). Gender bias in mortality does take an astonishingly heavy toll.

Some economic models have tended to relate the neglect of women to the lack of economic empowerment of women. While Ester Boserup, an early feminist economist, discussed how the status and standing of women are enhanced by economic independence (such as gainful employment), others have tried to link neglect of girls to the higher economic returns for the family from boys compared with girls. Still, women’s gainful employment, especially in more rewarding occupations, clearly does play a role in improving the deal that women and girls get.

And so does women's literacy, and other factors that can be seen adding to the status, standing and voice of women in family decisions. An example that can be discussed in this context is the experience of the State of Kerala in India, which provides a sharp contrast with many other parts of the country in having little or no gender bias in mortality. Indeed, not only is the life expectancy of Kerala women at birth above 76 (compared with 70 for men), the female male ratio of Kerala's population is 1.06 according to the 2001 Census (possibly somewhat raised by greater migration for work by men, but certainly no lower than the West European or North American ratios, which are around 1.05 or so). With its 30 million population, Kerala's example also involves a fair number of people. The causal variables related to women's empowerment can be seen as playing a role here, since Kerala has a very high level of women's literacy (nearly universal for the younger age groups), and also much more access for women to well paid and well respected jobs. One of the other influences of women's empowerment, namely a fertility decline, is also observed in Kerala, where the fertility rate has fallen very fast (much faster, incidentally, than China, despite the rigours of Chinese coercive measures in birth control), and Kerala's present fertility rate around 1.7 or 1.8 (roughly interpretable as an average of 1.7 or 1.8 children per couple) is one of the lowest in the developing world (about the same in Britain and France, and much lower than in the United States). All these observations link with each other very well in a harmonious causal story. However, there is further need for causal discrimination in interpreting Kerala's experience. There are other special features of Kerala which may also be relevant, such as female ownership of property for an influential part of the Hindu population (the Nairs), openness to and interaction with the outside world (with the presence of Christians – about a fifth of the population – who have been much longer in Kerala – since around the fourth century – than they have been in, say, Britain, not to mention who came to Kerala shortly after the fall of Jerusalem), and activist left-wing politics with a particularly egalitarian commitment, which has tended to focus strongly on issues of equity (not only between classes and castes, but also between women and men).

There are some other issues which can be the indicating factors in analyzing the problems of gender bias and are quite widely observed in South Asia. These are: (1) undernourishment of girls over boys, (2) high incidence of maternal

undernourishment, (3) prevalence of low birth weight, (4) high prevalence of cardiovascular diseases. Let us have a brief discussion on these issues.

At the time of birth, girls are obviously no more nutritionally deprived than boys are, but this situation changes as society's unequal treatment takes over from nature's non-discrimination. There has, in fact, been plenty of aggregative evidence on this for quite some time now. But this has been accompanied by some anthropological scepticism of the appropriateness of using aggregate statistics with pooled data from different regions to interpret the behaviour of individual families. However, there have also been some detailed and concretely local studies on this subject, which confirm the picture that emerges on the basis of aggregate statistics. In one case study from India, undertaken in 1983, involved the weighing of every child in two large villages. The time pattern that emerged from this micro study, which concentrated particularly on weight-for-age as the chosen indicator of nutritional level for children under five, brings out clearly how an initial condition of broad nutritional symmetry turns gradually in to a situation of significant female disadvantage. The detailed local studies tend to confirm rather than contradict the picture that emerges from aggregate statistics. In interpreting the causal process, it is important to emphasize that the lower level of nourishment of girls may not relate directly to their being underfed vis-à-vis boys. Often enough, the differences may particularly arise from the neglect of health care of girls compared with what boys get. In South Asia maternal under nutrition is more common than in most other regions of the world. Comparisons of Body Mass Index (BMI), which essentially a measure of weight for height, bring this out clearly enough, as do statistics of such consequential characteristics as the incidence of anaemia. In South Asia, as many as 21 per cent of children are born clinically underweight (in accepted medical standards) – more than in any other substantial region in the world. The predicament of being low in weight in childhood seems often enough to begin at birth in the case of South Asian children. In terms of weight for age, South Asia has around 40 to 60 per cent children under nourished compared with 20 to 40 per cent under nourishment even in sub-Saharan Africa. The children start deprived and stay deprived. South Asia stands out as having more cardiovascular diseases than many other part of the third world. Even when other countries, such as China, have greater prevalence of the standard predisposing conditions, the Indian population seems to have more heart problems than these other

countries have. It is not difficult to see that the first three observations are very likely causally connected. The neglect of the care of girls and of women in general and the underlying gender bias that they reflect would tend to yield more maternal undernourishment, and through that more fetal deprivation and distress, underweight babies, and child undernourishment. According to the pioneering work of a British medical team, led by Professor D.J.P. Barker, low birth weight is closely associated with higher incidence of several adult diseases, including hypertension, glucose intolerance, and other cardiovascular hazards. High incidence of cardiovascular diseases in South Asia strongly suggests a causal pattern that goes from the nutritional neglect of women to maternal undernourishment, from there to fetal growth retardation and underweight babies, and thence to greater incidence of cardiovascular afflictions much later in adult life (along with the phenomenon of undernourished children in the shorter run). What begins as a neglect of the interests of women ends up causing adversities in the health and survival of all – even at an advanced age. Given the uniquely critical role of women in the reproductive process, it would be hard to imagine that the deprivation to which women are subjected would not have some adverse impact on the lives of all – men as well as women and adults as well as children – who are “born of a woman”. These biological connections illustrate a more general point, to wit, gender inequality can hurt the interests of men as well as women. There are other – non-biological – connections that operate through women’s conscious agency. The expansion of women’s capabilities not only enhances women’s own freedom and well-being, but also has many other effects on the lives of all. An enhancement of women’s active agency can, in many circumstances, contribute substantially to the lives of all people – men as well as women, children as well as adults. As many studies have brought out, the greater empowerment of women tends to reduce child neglect and mortality, cut down fertility and overcrowding, and more generally, broaden social concern and care. While there is something to cheer in the developments, there is considerable evidence of a weakened hold of gender disparity in several fields in the subcontinent, there is also, alas, some evidence of a movement in the contrary direction, at least in one aspect of gender inequality, namely, natality inequality. This has been brought out particularly sharply by the early results of the 2001 decennial national Census of India, which are now available. Early results indicate that even though the overall female to male ratio has improved slightly for the country as a whole (with a corresponding reduction of the proportion of “missing

women”), the female-male ratio for children has had a substantial decline. For India as a whole, the female-male ratio of the population under age six has fallen from 94.5 girls for 100 boys in 1991 to 92.7 girls per hundred boys in 2001. While there has been no such decline in some parts of the country (most notably Kerala), it has fallen very sharply in others, such as Punjab, Haryana, Gujarat and Maharashtra, which are among the richer Indian States. Taking together all the evidence that exists, it is clear that this change reflects not a rise in female child mortality, but a fall in female births vis-à-vis male births, and is almost certainly connected with increased availability and use of gender determination of fetuses. Fearing that sex selective abortion might occur in India, the Indian Parliament banned some years ago the use of sex determination techniques for fetuses, except when it is a by-product of other necessary medical investigation. But it appears that the enforcement of this law has been comprehensively neglected, and the police often cited difficulties in achieving successful prosecution for the reluctance of mothers to give evidence of use of such techniques. The reluctance of the mothers to give evidence brings out perhaps the most disturbing aspect of this natality inequality, to wit, the “son preference” that many Indian mothers themselves seem to have. This face of gender inequality can not, therefore, be removed, at least in the short run, by the enhancement of women empowerment and agency, since that agency is itself an integral part of the cause of natality inequality. Policy initiatives have to take adequate note of the fact that the pattern of gender inequality seems to be shifting in India, right at this time, from mortality inequality (the female life expectancy at birth is by now two years higher than male life expectancy in India) to natality inequality. Indeed, there is clear evidence that traditional routes of changing gender inequality, through using public policy to influence female education and female economic participation, may not serve as a path to the removal of natality inequality. A sharp pointer in that direction comes from countries in East Asia, which all have high levels of female education and economic participation. Despite these achievements, compared with the biologically common ratio across the world of 95 girls being born per hundred boys, Singapore and Taiwan have 92 girls, South Korea only 88, and China a mere 86. in fact, South Korea’s overall female-male ratio for children is also a meager 88 girls for 100 boys and China’s 85 girls for 100 boys. In comparison, the Indian ratio of 92.7 girls for 100 boys (though lower than its previous figure of 94.5) still looks far less unfavourable. However, there are more grounds for concern than may be suggested by the current

all-India average. First, there are substantial variations within India, and the all-India average hides the fact that there are States in India where the female-male ratio for children is very much lower than the Indian average. Second, it has to be asked whether with the spread of sex-selective abortion, India may catch up with – and perhaps even go beyond – Korea and China. There is, in fact, strong evidence that this is happening in a big way in parts of the country. There is, however, something of a social and cultural divide across India, splitting the country into two nearly contiguous halves, in the extent of anti-female bias in natality and post-natality mortality. Since more boys are born than girls everywhere in the world, even without sex-specific abortion, we can use as a classificatory benchmark the female-male ratio among children in advanced industrial countries. The female-male ratio for the 0-5 age group is 94.8 in Germany, 95.0 in U.K., and 95.7 in the U.S., and perhaps we can sensibly pick the German ratio of 94.8 as the cut-off point below which we should suspect anti-female intervention. The use of this dividing line produces a remarkable geographical split of India. There are the States in the north and the west where the female-male ratio of children is consistently below the benchmark figure, led by Punjab, Haryana, Delhi and Gujarat (with ratios between 79.3 and 87.8), and also including, among others, Himachal Pradesh, Madhya Pradesh, Rajasthan, Uttar Pradesh, Maharashtra, Jammu and Kashmir, and Bihar (a tiny exception is Dadra and Nagar Haveli, with less than a quarter million people altogether). On the other side of the divide, the States in the east and the south tend to have female-male ratios that are above the benchmark line of 94.8 girls per 100 boys: with Kerala, Andhra Pradesh, West Bengal and Assam (each between 96.3 and 96.6), and also, among others, Orissa, Karnataka and the northeastern States to the east of Bangladesh (Meghalaya, Mizoram, Manipur, Nagaland, Arunachal Pradesh). One significant exception to this neat pattern of adjoining division is, however, provided by Tamil Nadu, where the female-male ratio is just below 94, which is higher than the ratio of any State in the deficit list, but still just below the cut-off line used for the partitioning (94.8). The astonishing finding is not that one particular State seems to provide a marginal misfit, but how the vast majority of the Indian States fall firmly into two contiguous halves, classified broadly into the north and the west, on one side, and the south and the east, on the other. Indeed, every State in the north and the west (with the slight exception of the tiny Union Territory of Dadra and Nagar Haveli) has strictly lower female-male ratio of children than every State in the east and the south (even Tamil Nadu fits into

this classification), and this indeed is quite remarkable. The pattern of female-male ratio of children produces a much sharper regional classification than does the female-male ratio of mortality of children, even though the two are also fairly strongly correlated. The female-male ratio in child mortality varies between 0.91 in West Bengal and 0.93 in Kerala, on one side, in the southern and eastern group, to 1.30 in Punjab, Haryana and Uttar Pradesh, with high ratios also in Gujarat, Bihar and Rajasthan, in the northern and western group. The north and the west have clear characteristics of anti-female bias in a way that is not present – or not yet visible – in most of the east and the south. This contrast does not have any immediate economic explanation. The States with anti-female bias include rich ones (Punjab and Haryana) as well as poor States (Madhya Pradesh and Uttar Pradesh), and fast-growing States (Gujarat and Maharashtra) as well as growth failures (Bihar and Uttar Pradesh). Also, the incidence of sex-specific abortions can not be explained by the availability of medical resources for determining the sex of the fetus: Kerala and West Bengal in the non-deficit list, both with the ratio of 96.3 girls to 100 boys (comfortably higher than the benchmark cut-off of 94.8), have at least as much medical facilities as in such deficit States as Madhya Pradesh or Rajasthan. If commercial facilities for sex-selected abortion are infrequent in Kerala or West Bengal, it is because of a low demand for those specific services, rather than any great supply side barrier. This suggests that we have to look beyond economic resources or material prosperity or GNP growth into broadly cultural and social influences. There are a variety of potential connections to be considered here, and the linking of these demographic features with the rich subject matter of social anthropology and cultural studies would certainly be important to pursue. There is perhaps a common link with politics as well. Indeed, it has been noted, in other contexts, that the States in the north and the west have, by and large, given much more room to religion-based sectarian politics than have the east or the south, where religion-centered parties have had very little success. The remarkable geographical division of India into two largely contiguous parts in terms of female-male ratio among children (reflecting the combined influence of inequality in natality and post-natal mortality) does call for acknowledgement and further analysis. It would also be important to keep a close watch on whether the incidence of sex-specific abortions will significantly increase in states in which they are at this time quite uncommon. Firstly, the prominent faces of gender injustice can vary from one region to another, and also from one period to the next. Secondly, the

effects of gender inequality, which can impoverish the lives of men as well as women, can be more fully understood by taking detailed empirical note of specific forms of inequality that can be found in particular regions. Gender inequality hurts the interests not only of girls and grown-up women, but also of boys and men, through biological connections (such as childhood undernourishment and cardiovascular diseases at later ages) and also through social connections (including in politics and in economic and social life). To have an adequate appreciation of the far-reaching effects of disparities between women and men, we have to recognize the basic fact that gender inequality is not one affliction, but many, with varying reach on the lives of women and men, and of girls and boys. There is also the need to reexamine and closely scrutinize some lessons that we have tended to draw from past empirical works. There are no good reasons to abandon the understanding that the impact of women's empowerment in enhancing the voice and influence of women does help to reduce gender inequality of many different kinds, and can also reduce the indirect penalties that men suffer from subjugation of women. However, the growing phenomenon of natality inequality raises questions that are basically much more complex. When women in some regions themselves strongly prefer having boys to girls, the remedying of the consequent natality inequality calls at least for broader demands on women's agency, in addition to examining other possible influences. Indeed, in dealing with the new – “high tech” – face of gender disparity, in the form of natality inequality, there is a need to go beyond just the agency of women, but to look also for more critical assessment of received values. When anti-female bias in action (such as sex-specific abortion) reflects the hold of traditional masculinist values from which mothers themselves may not be immune, what is needed is not just freedom of action but also freedom of thought – in women's ability and willingness to question received values. Informed and critical agency is important in combating inequality of every kind. Gender inequality, including its many faces, is no exception.

Thus, it is well understood that the health of the women is not only important for the women folk but also for the men folk too. So, there is a burning need of addressing the gender-specific health needs of women. And this can not be dealt with in a social vacuum. The whole familial, environmental, social, economic, political, educational, geographical, cultural aspects of a woman's life should be taken into consideration, because, each and every aspect of a women's life is interrelated and has

a great impact on her health status. So these problems should be highlighted and taken care of, in order to move towards the ultimate goal of human development, which can not be a complete one leaving the women folk behind.