1.1. BACKGROUND

While gender disparities in health and education outcomes are higher on average in South Asian than in other countries, the large within country differences in gender disparity, between Indian states demand more local explanations..... The World Bank

Gender is a social construct, opposed to, sex and is defined by FAO as ‘the relations between men and women, both perceptual and material. Gender is not determined biologically, as a result of sexual characteristics of either women or men, but is constructed socially\(^1\). While, gender disparity is the differences between the sexes that are, not anatomical or biological but are due to the influences of culture and society. Gender disparity, manifest themselves in the extent to which the attitudes and behavior of men and women diverge in public and private life, in their choice of occupation, their ambitions, and their aspirations. Male and female roles can also vary markedly from one society or period in history to another, pointing to the determining influence of culture on gender roles. It has been reasonably
argued, however, that gender differences are purely arbitrary (not fixed), and nurtured by the society based on prevailing cultural norms.

The gender disparity, once widely seen across the countries and religions has begun to change during the last few decades in some parts of the world. However, in most traditional societies, the women were generally at a disadvantage. Their education was limited to learning domestic skills, and they had no access to positions of power. Marriage was almost a necessity as a mean of support or protection, and pressure was usually constant to produce children, especially male heirs. As such, a woman had no legal control over her person, her own land and money, or her children. According to a double standard of morality, respectable women had to be chaste but respectable men did not and women were seen mainly as baby-carriers and homemakers. This situation has begun to change during late 19th and early 20th century. Such changing scenario has brought in considerable changes in the lives of women, in the developed world that is evident form the World Bank’s Human Development Report. As for developing nations are concerned, little has changed although, the degree of gender stratification is not uniform throughout the complex society. It varies by social class and possibly race/ethnicity or region.

From many perspectives women in South Asia, which consist of seven countries namely, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka, find themselves in subordinate positions to men and are socially, culturally, and economically dependent on them.
1.2. DEMOGRAPHIC PROFILE OF SOUTH ASIA

All seven countries are part of South Asian Association for Regional Cooperation (SAARC) and has a population of almost 1.5 billion people, the combined population of its member states. Further, population distribution can be found in the table given below. Each country varies in the proportion of agricultural population and the proportion of gross domestic product from agriculture and animal husbandry. From the religious perspective, Islamic religion is dominant in Pakistan, Bangladesh, and the Maldives. Hinduism dominates in India and Nepal. Buddhists are the majority in Bhutan and Sri Lanka. The Maldives and Sri Lanka average 4.5-5.5 years of schooling compared to about 2 years and high rates of female illiteracy in the other countries. All countries have low-income economies. During 1950-90 population in SAARC countries doubled. The growth rate averaged 3.63% per year. India alone had over 75% of total SAARC population in 1990. Population decline began in Sri Lanka in 1950, in India in 1970, in Bangladesh in 1980, and in the Maldives and Nepal in 1990. Population decline in Bhutan is not evident. Population density is low in Bhutan, in part because of limited habitable land. Population density is very high in Bangladesh, followed by the Maldives, where 26% of total population is concentrated in Male. Over 68% of population in each country lived in rural areas in 1990. The expected population shifts by 2025 vary by country.

In all countries, with the exception of Sri Lanka, over 35% are children and 40-48% are dependents. Until 1990 there were more surviving males. Only Sri Lanka and Bhutan had a balanced sex ratio in 1990. There were more single males and females in Sri Lanka, which also had the lowest
proportion of ever married girls aged 15-19 years. Only Sri Lanka (1990) had close to replacement fertility (2.5). Fertility ranged from 3.9 in India to 5.9 in Bhutan.

I - Population and Life Expectancy Profile of South Asian Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Total population(000)</th>
<th>Life expectancy</th>
<th>Probability of dying under age 5 years (per 1000)</th>
<th>Healthy life expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Mala</td>
<td>Female</td>
<td>Mala</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>143,809</td>
<td>62.6</td>
<td>62.6</td>
<td>62.6</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2190</td>
<td>61.3</td>
<td>60.2</td>
<td>62.4</td>
</tr>
<tr>
<td>India</td>
<td>1049549</td>
<td>61.1</td>
<td>60.1</td>
<td>62.0</td>
</tr>
<tr>
<td>Maldives</td>
<td>309</td>
<td>66.1</td>
<td>66.5</td>
<td>65.6</td>
</tr>
<tr>
<td>Nepal</td>
<td>24609</td>
<td>60.1</td>
<td>59.9</td>
<td>60.2</td>
</tr>
<tr>
<td>Pakistan</td>
<td>149911</td>
<td>61.4</td>
<td>61.1</td>
<td>61.6</td>
</tr>
<tr>
<td>Srilanka</td>
<td>18910</td>
<td>70.3</td>
<td>67.2</td>
<td>74.3</td>
</tr>
</tbody>
</table>

Source: Fariyal F Fikree, Omrana Pasha, Role of gender in health disparity: The South Asian context, (BMJ 2004; 328:823–6)

1.3. GENDER DISPARITY IN SOUTH ASIA

In south Asia, the women are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility, and are often under threat of violence from male relatives. Sons are perceived to have economic, social, or religious utility; daughters are often felt to be an economic liability because of the dowry system. Many studies have documented that gender disparity is in its worst form in south Asian countries compared to developed countries. While gender disparities in health and education outcomes are higher on average in South
Asian than in other countries, the large within-country differences in gender disparity, between Indian states or Pakistan provinces demand more local explanations.

Further, there are regional variations in the extent of gender disparity in these countries. To highlight the degree of gender disparity in South Asia the researcher wish to discuss 6 parameters which include data on GDI, GEM, Life expectancy, Adult literacy rate, estimated earned income and HDI rank. Overall HDI rank for South starts from Srilanka with 99th rank to Nepal 142 rank. India which accounts to 85% of south Asia scored HDI rank of 128 up from 105 in the year 2000. Gender-related Development index (GDI) rank for India was 112 in the year 2005. Gender empowerment measure rank put three Muslim states namely Maldives, Bangladesh and Pakistan ahead of other states in the region. Adult literacy ratio of female rate to male rate is 0.97 for Srilanka which is far ahead of other countries in the region. Life expectancy at birth is 63.3 for females in India which is far less compared to Srilanka whose life expectancy at birth for female is 75 comparable to developed countries. Earned income of women appears to be the favorable for factor for enhancement in all the above parameters, as earned income for the women in Srilanka was 2193 USD compared to Indian women whose earned income in the year 1999 was USD 1195. Hence it is possible to infer that the status of women in south Asia, the single exception is Srilanka, not so good, on many fronts when compared to women born in the developed countries. Particularly, the pre-existing gender norms and values, contribute to the gender stereotyping in South Asia.
Further, owing to prevailing gender disparity, the women are less likely to seek appropriate and early care for disease. Yet the frequency with which such care is required, burden of disease, morbidity, health seeking behavior, social and economical determinants and the quality of care provided to women etc., have not been well documented in South Asia. The difference in gender disparity between the states and provinces within the region further requires local explanation. In south Asia; India, Bangladesh, and Pakistan constitute almost 97% of the population in South Asia of which India alone contributes to 85 % of the region. Hence, the researcher decided to focus his research on India which has wide internal disparity.

II - HDI AND GEM IN SOUTH ASIAN COUNTRIES

<table>
<thead>
<tr>
<th>HDI Rank of Countries in South Asia</th>
<th>GDP per capita (PPP US$)</th>
<th>GDP per capita (PPP US$) rank</th>
<th>Gender-related development index (GDI) value</th>
<th>Gender-related development index (GDI) rank</th>
<th>Gender empowerment measure (GEM) value</th>
<th>Gender empowerment measure (GEM) rank</th>
<th>Adult literacy rate (ratio of female rate to male rate)</th>
<th>Gross primary enrolment ratio (ratio of female ratio to male ratio)</th>
<th>Gross secondary enrolment ratio (ratio of female ratio to male ratio)</th>
<th>Gross tertiary enrolment ratio (ratio of female ratio to male ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99 Sri Lanka</td>
<td>4,595 7 88 0.735 85 0.369 0.97 0.99 1</td>
<td>100 Maldives 5,261 -1 84 0.744 76 0.437 1 0.98 1.14 2.37</td>
<td>128 India 3,452 -11 112 0.6 .. .. 0.65 0.94 0.8 0.7</td>
<td>136 Pakistan 2,370 -8 124 0.525 82 0.377 0.55 0.76 0.74 0.88</td>
<td>140 Bangladesh 2,053 0 120 0.539 81 0.379 0.76 1.03 1.03 0.53</td>
<td>142 Nepal 1,550 8 127 0.52 86 0.351 0.56 0.91 0.86 0.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In this study, further discussion, will be focused on, the status of women in India and the various initiatives of Govt of India that were/are aimed at women empowerment in India. At the end, the researcher will compare the data obtained form the study and compare them with South Asia countries on four counts i.e., women’s education, disease and treatment seeking behavior and nutritional profile.

1.4. PROBLEMS OF WOMEN IN INDIA

Women born India has limited access to education or employment, high illiteracy rates and more often find themselves below poverty levels are making health improvements for women exceedingly difficult. Right from the childhood women perform multiple productive functions apart from reproductive roles in the developing world. During childhood she is forced to forego her schooling to look after her siblings, and assist her mother in house hold activities. When she attains puberty she is forced into wedlock while her reproductive organs are still developing. Thereafter, she has to provide care to her children and contribute to the family income. As she grows older ends up all alone to look after her own self. Such hectic life event denies opportunity for a woman to learn, take decisions, eat good food and access quality health care.

Gender discrimination shown at each stage of a female life cycle contributes to health disparity, sex selective abortions, neglect of girl children, reproductive mortality, and poor access to health care. Therefore, a woman’s access to quality basic health care, apart from family planning and obstetric services need to be improved and sustained throughout the life cycle which is not currently available. The situation of women in India is an extraordinarily
different and difficult topic to discuss, since there is no nation in the world with
greater internal diversity and plurality. For example, India exhibits\textsuperscript{9} wide
variations in the degree of son preference, with stronger son preference found,
in northern India than in the south. Further, gender disparity is uniform across
communities cutting across economic barriers, as there is almost no
correlation between per capita income and the gender disparities in health
and education outcomes\textsuperscript{10}.

Constitution of India provides, rights of non-discrimination on the
basis of sex, and this is guaranteed in the list of justifiable fundamental rights.
Constitution of India not only grant equality to women but also empowers the
state to adopt measures of positive discrimination in favor of women for
removing the cumulative socio, economic, educational and political
disadvantages faced by women. Even though gender equality has been
enshrined in the constitution of India, women’s live are circumscribed by
custom and religion in praxis. Various measures have been instituted by the
Government of India from time to time. Five year plans – the major strategy
for India’s development, in deed, conceptualized different strategies to ensure
advancement of women in India. Vanaja\textsuperscript{11} argues that only in 6\textsuperscript{th} five year plan
a separate section has been added to address the issues of concern for
women and in 7\textsuperscript{th} plan attitudinal change in society regarding involvement of
women in development was recognized as important to address women’s
issues. Gender advancement initiatives in the 5 year plans are summarized
in the table given below.
1.5. FIVE-YEAR PLANS FOR WOMEN DEVELOPMENT IN INDIA

<table>
<thead>
<tr>
<th>Five Year Plans</th>
<th>Women Advancement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Five Year Plan</strong></td>
<td>It was mainly welfare oriented as far as women’s issues were concerned. The Central Social Welfare Board (CSWB) undertook a number of welfare measures through the voluntary sector. The programmes for women were implemented through the National Extension Service Programmes through Community Development Blocks.</td>
</tr>
<tr>
<td>(1956-61)</td>
<td></td>
</tr>
<tr>
<td><strong>2nd Five Year Plan</strong></td>
<td>Efforts were geared to organize “Mahila Mandals” (women’s groups) at grass-roots levels to ensure better implementation of welfare schemes.</td>
</tr>
<tr>
<td>(1956-61)</td>
<td></td>
</tr>
<tr>
<td><strong>3rd, to 5th and other Interim Plans</strong> (1961-74)</td>
<td>They accorded high priority to women’s education. Measures to improve maternal and child health services, and supplementary feeding for children, nursing and expectant mothers were also introduced.</td>
</tr>
<tr>
<td><strong>4th Five Year Plan</strong></td>
<td></td>
</tr>
<tr>
<td>(1969-74):</td>
<td></td>
</tr>
<tr>
<td><strong>5th Five Year Plan</strong></td>
<td></td>
</tr>
<tr>
<td>(1974-79):</td>
<td></td>
</tr>
<tr>
<td><strong>6th Five Year Plan</strong></td>
<td>This is regarded as a landmark in women’s development. The Plan adopted a multidisciplinary approach with a three pronged thrust on health, education and employment of women.</td>
</tr>
<tr>
<td>(1980-85):</td>
<td></td>
</tr>
<tr>
<td><strong>7th Five Year Plan</strong></td>
<td>Development programmes for women were continued, with the objective of raising their economic and social status and bring them into the mainstream of national development. A very significant step therein was to identify and promote “beneficiary-oriented programmes” which extended direct benefits to women.</td>
</tr>
<tr>
<td>(1985-90):</td>
<td></td>
</tr>
<tr>
<td><strong>8th Five Year Plan</strong></td>
<td>It attempted to ensure that the benefits of development from different sectors did not bypass</td>
</tr>
<tr>
<td>(1992-97):</td>
<td></td>
</tr>
</tbody>
</table>
women. Special programmes were implemented to complement the general development programmes. The flow of benefits to women in the three core sectors of education, health and employment were monitored vigilantly. Women were enabled to function as equal partners and participants in the developmental process with reservation in the membership of local bodies. This approach of the Eighth Plan marks a definite shift from ‘development’ to ‘empowerment’ of women.

<table>
<thead>
<tr>
<th>9th Five Year Plan (1997-2002):</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ninth Five Year Plan envisaged:</td>
</tr>
<tr>
<td>a) Empowerment of women and socially disadvantaged groups such as Scheduled Castes, Scheduled Tribes and Other Backward Classes and Minorities as agents of socio-economic change and development.</td>
</tr>
<tr>
<td>b) Promoting and developing people’s participatory institutions like Panchayati Raj institutions, cooperatives and self-help groups.</td>
</tr>
<tr>
<td>c) Strengthening efforts to build self-reliance.</td>
</tr>
<tr>
<td>d) The convergence of services from different sectors.</td>
</tr>
<tr>
<td>e) A women’s component plan at the Central and State levels.</td>
</tr>
<tr>
<td>f) 27 Beneficiary Oriented Schemes (BOS) for women was put into action</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10th Five Year Plan (2002-2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Tenth Five Year Plan was formulated to ensure requisite access of women to information, resources, and services, and advance gender equality goals.</td>
</tr>
<tr>
<td>Translated gender commitment into budgetary commitment to ensure that women receive their</td>
</tr>
</tbody>
</table>


1.6. INDIA’S NATIONAL POLICY FOR THE EMPOWERMENT OF WOMEN (2001)

Apart from the five year plans, Government of India has framed a National Policy for the Women Empowerment\(^\text{12}\) in the year 2001. This policy document confirms that, only from the Fifth Five Year Plan (1974-78) onwards, there has been a marked shift in the approach to women’s issues from welfare to development. In recent years, the empowerment of women has been recognized as the central issue in determining the status of women. The National Commission for Women was set up by an Act of Parliament in 1990 to safeguard the rights and legal entitlements of women. The 73\(^\text{rd}\) and 74\(^\text{th}\) amendments (1993) to the Constitution of India have provided for reservation of seats in the local bodies of Panchayats and Municipalities for women, laying a strong foundation for their participation in decision making at the local levels.

Reservation at pachayat raj institutions is a smart beginning. However, realizing the constitutional provisions is a long way to go and further
concerted efforts are needed before ensuring gender equity and equality. Empowerment policy statements 1.8-1.10 add that gender disparity manifests itself in various forms, the most obvious being the trend of continuously declining female ratio in the population in the last few decades. Social stereotyping and violence at the domestic and societal levels are some of the other manifestations. Discrimination against girl children, adolescent girls and women persists in parts of the country.” The underlying causes of gender inequality are related to social and economic structure, which is based on informal and formal norms, and practices. The access of women, particularly, those belonging to weaker sections including Scheduled Castes/Scheduled Tribes/ Other backward Classes and minorities, majority of whom are in the rural areas and in the informal, unorganized sector, to education, health and productive resources, among others, is inadequate. Therefore, they remain largely marginalized, poor and socially excluded.

Some of the goals set by the policy document that are relevant to health sector are: objectives 3 and 4 which state that (i) Equal access to participation and decision making of women in social, political and economic life of the nation and (ii) Equal access to women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office etc. Certain “Policy prescriptions” are also pronounced by the policy document. The most important prescription in that all measures will be taken to guarantee women equal access to and full participation in decision making bodies at every level, including the legislative, executive, judicial, corporate, statutory bodies, as also the advisory Commissions, Committees, Boards,
Trusts etc. Affirmative action such as reservations/quotas, including in higher legislative bodies, will be considered whenever necessary on a time bound basis. Unfortunately, women reservation bill that is supposed to reserve 33% of seats in the parliament is still in the preparatory stages and no government is keen in making this come true.

Policy prescription for social empowerment of women lies in education, health and nutrition. In the field of education, policy document prescribes that 6.1 Equal access to education for women and girls will be ensured. Special measures will be taken to eliminate discrimination, universalize education, eradicate illiteracy, create a gender-sensitive educational system, increase enrolment and retention rates of girls and improve the quality of education to facilitate life-long learning as well as development of occupation/vocation/technical skills by women. Reducing the gender gap in secondary and higher education would be a focus area. Sectoral time targets in existing policies will be achieved, with a special focus on girls and women, particularly those belonging to weaker sections including the Scheduled Castes/Scheduled Tribes/Other Backward Classes/Minorities. Gender sensitive curricula would be developed at all levels of educational system in order to address sex stereotyping as one of the causes of gender discrimination.

With regard to health, the policy document prescribes (6.2) a holistic approach to women’s health which includes both nutrition and health services will be adopted and special attention will be given to the needs of women and the girl at all stages of the life cycle. The reduction of infant
mortality and maternal mortality, which are sensitive indicators of human
development, is a priority concern. Measures will be adopted that take into
account the reproductive rights of women to enable them to exercise informed
choices, their vulnerability to sexual and health problems together with
endemic, infectious and communicable diseases such as malaria, TB, and
water borne diseases as well as hypertension and cardio-pulmonary diseases.
The social, developmental and health consequences of HIV/AIDS and other
sexually transmitted diseases will be tackled from a gender perspective.
Section 6.3 states that, to effectively meet problems of infant and maternal
mortality, and early marriage the availability of good and accurate data at
micro level on deaths, birth and marriages is required. In strict
implementation of registration of births and deaths would be ensured and
registration of marriages would be made compulsory.

Women’s traditional knowledge (6.5) about health care and
nutrition will be recognized through proper documentation and its use will be
encouraged. The use of Indian and alternative systems of medicine will be
enhanced within the framework of overall health infrastructure available for
women.

Nutrition which is a cause of concern due to and for much
unfavorable status of women, is addressed by the policy document. Document
prescribes that (6.6) in view of the high risk of malnutrition and disease that
women face at all the three critical stages viz., infancy and childhood,
adolescent and reproductive phase, focused attention would be paid to
meeting the nutritional needs of women at all stages of the life cycle. This is
also important in view of the critical link between the health of adolescent girls,
pregnant and lactating women with the health of infant and young children. Special efforts will be made to tackle the problem of macro and micro nutrient deficiencies especially amongst pregnant and lactating women as it leads to various diseases and disabilities.

Intra-household discrimination (6.7) in nutritional matters vis-à-vis girls and women will be sought to be ended through appropriate strategies. Widespread use of nutrition education would be made to address the issues of intra-household imbalances in nutrition and the special needs of pregnant and lactating women. Women’s participation will also be ensured in the planning, supervision and delivery of the system. In achieving these prescriptions, policy documents spelt that all central and state ministries will draw up time bound action plans measurable goals to be achieved by 2010. Not many departments have released time bound goals and set any targets. Some of the operational strategies proposed in this direction are:

1. Gender budgeting
2. Formation of national and state committees to oversee the operationalisation of the policy
3. Establishment of national and state resource centre on women
4. Not less than 30 % benefits/funds flow to women all ministries
5. Strict enforcement of relevant legal provisions
6. Gender sensitization training and
7. Partnership with voluntary sector and international cooperation.

strategies proposed by the policy document.
To sum up, status of women through the centuries has not changed much. Governments, state and central, are needed to be geared-up to address this disparity and draw systematic and time-bound action plans. Though “the empowerment of women” included as one of the primary objectives of various plans, no serious attempts were made to achieve the goals in the past. Thus necessitating a micro level study to understand one of the primary issues that is, health inequality, that affects the women of all class, caste and religion and to provide local explanation on the issue concern to overcome the barriers.
Footnotes


