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Role of gender in health disparity: the South Asian context

Fariyal F Fikree, Omrana Pasha

South Asia's girls and women do not have the same life advantage as their Western counterparts. A human rights based approach may help to overcome gender related barriers and improve the wellbeing of men, women, and children.

Introduction

Behaviour has an important role in health disparities—for example, young men take greater risks, causing injury and violent death, and men smoke more.[1] In industrialised countries women are born with an advantage; their healthy life expectancy is two years longer and their life expectancy six years longer than those of men.[2] This advantage is prominent in childhood; girls are more likely to survive the first five years of life than boys.[2] However, does this female advantage endure in parts of the world where gender discrimination exists? We present the case of South Asia to illustrate the role that gender has on health.

Summary points

The life advantage for girls and women that characterises the health statistics of industrialised countries is blurred in South Asia

Gender discrimination at each stage of the female life cycle contributes to health disparity, sex selective abortions, neglect of girl children, reproductive mortality, and poor access to health care for girls and women

The violation of fundamental human rights, and especially reproductive rights of women, plays an important part in perpetuating gender inequity

Policy makers, programme managers, health professionals, and human rights workers in South Asia need to be aware of and responsive to the detrimental health effects that gender plays throughout the life cycle

The role of gender in South Asia

From many perspectives women in South Asia find themselves in subordinate positions to men and are socially, culturally, and economically dependent on them.[3] 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.[4] Sons are perceived to have economic, social, or religious utility; daughters are often felt to be an economic liability because of the dowry system.[5]

We believe that individual and societal beliefs about and attitudes towards appropriate gender specific roles, and the choices of individuals and households on the basis of these factors, mean that women are disadvantaged with regard to health and health care. There are some instances in which gender differences hurt men's health—for example, men are more likely to be involved in road crashes or occupational accidents as they are more likely to be outside the home or in a workplace than women. However, most of the evidence shows that gender inequalities have led to a systematic devaluing and neglect of women's health.

Established gender norms and values contribute to the loss of the "female advantage" in South Asia. In contrast to industrialised countries, healthy life expectancy is equal or shorter in women than in men in nearly all these countries. The probability of surviving the first five years of life for girls is equal to or smaller than that for boys (table). The single exception is Sri Lanka, which has indicators that reflect both improved overall health status of the population and a paucity of evidence of female disadvantage. India, Bangladesh, and Pakistan constitute almost 97% of the population in South Asia, and our comments will focus on these countries.

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Life expectancy indicators for South Asian countries[2]

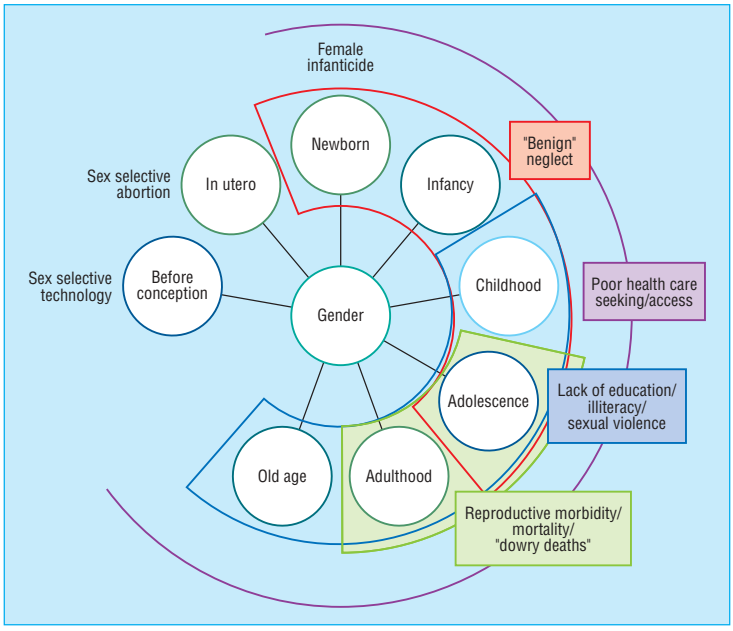
Country	Total population (000)	Life expectancy			Probability of dying under age 5 years (per 1000)		Healthy life expectancy at birth		
		Total	Male	Female	Male	Female	Total	Male	Female
Bangladesh	143 809	62.6	62.6	62.6	71	73	54.3	55.3	53.3
Bhutan	2 190	61.3	60.2	62.4	93	92	52.9	52.9	52.9
India	1 049 549	61.0	60.1	62.0	87	95	53.5	53.3	53.6
Maldives	309	66.1	66.5	65.6	38	43	57.8	59.0	56.6
Nepal	24 609	60.1	59.9	60.2	81	87	51.8	52.5	51.1
Pakistan	149 911	61.4	61.1	61.6	105	115	53.3	54.2	52.3
Sri Lanka	18 910	70.3	67.2	74.3	20	16	61.6	59.2	64.0

Life cycle of gender discrimination

Gender related differences in health status have led to an unbalanced sex ratio for the past 100 years, which is declining further.[6] An estimated 60-100 million girls are "missing" worldwide,[7 8] and the imbalanced sex ratios of South Asian countries contribute a large proportion of this number.[9 10] In some parts of the Indian subcontinent the sex ratio has fallen as low as 770 women per 1000 men.[11] Gender discrimination at each stage of the female life cycle contributes to this imbalance. Sex selective abortions, neglect of girl children, reproductive mortality, and poor access to health care for girls and women have all been cited as reasons for this difference (figure).

Sex selection

Since the advent of sex selection techniques before conception as well as in utero diagnosis and selective abortion of female fetuses, prenatal selection of male embryos has become common. One of the most disturbing aspects of this practice is that educated women who have frequent exposure to the media are the ones most likely to seek a sex selective abortion.[12] The most extreme form of sex selection, female infanticide, has focused international media attention on certain communities in India.[13 14] Reports from both the scientific literature and the local press show that this problem is likely to occur in various settings.[15 16]



Life cycle of gender discrimination and health

Neglect of girls

Less notorious but more far reaching than infanticide is the so called benign neglect that girls are subject to at all ages in South Asia. This has led to gender based health disparities among the population aged under 5 years that are larger than anywhere else in the world.[17] A girl between her first and fifth birthday in India or Pakistan has a 30-50% higher chance of dying than a boy.[17] This neglect may take the form of poor nutrition,[18–20] lack of preventive care (specifically immunisation),[18 21] and delays in seeking health care for disease.[22–24]

Health of adolescents

Early marriage and pregnancy,[25] anaemia,[26] sexual violence,[27] and poor educational opportunities all contribute to ill health among female adolescents in this region. Adolescents,[28] especially young women,[29] are disproportionately affected by HIV infection worldwide; adolescence is also a time when vulnerabilities to injury, including motor vehicle crashes and suicide, as well as substance abuse, rise.[30] In most parts of the world men bear the greater burden of violence and injuries[30]; however, suicide among young women may be more common in South Asia than in other parts of the world.[31–33] This, combined with the distressing practice of "dowry murder,"[34] means that young South Asian women are at a particular risk from violence. The current demographic trend of a rapidly growing young population[35] will increase the impact of adolescent health issues. Despite this, little attention has been paid to these conditions in the South Asian context of gender inequity.

The risks of reproduction

By their nature reproductive health hazards are borne by women alone. Poor outcomes for both mother and child are inevitable for a large proportion of the population as long as many South Asian mothers are too young,[25] receive minimal antenatal care,[36 37] and are malnourished[36 38] or anaemic[36 39 40] during pregnancy.

Poor vital registration systems in South Asia pose a challenge to measuring maternal mortality at the national level.[41] Maternal deaths—most commonly from haemorrhage, sepsis, and eclampsia—continue to exact a high toll; unsafe abortions also contribute to deaths from haemorrhage and sepsis.[36 38 41] Home deliveries by unskilled attendants, a paucity of knowledge of intrapartum danger signs, and poor transport mechanisms to and lack of appropriate care at health facilities all contribute to this burden.[36 42] Women cite economic circumstances and spousal or familial opposition to delivery in hospital as the most common reasons for delivery at home. Decisions about

seeking care in such emergencies are made largely by the husband or the elder members of his family.[36 43 44]

Health care for women

Women are less likely to seek appropriate and early care for disease. Yet the frequency with which such care is required—burden of disease, maternal mortality, and morbidity aside—and the quality of care provided to women has not been well documented in South Asia. In the authors' experience, diseases that generally have an equal prevalence in men and women are found to have affected women disproportionately in this region.[45–47] It remains unclear why South Asian women are more often affected by diseases such as rheumatic heart disease and hepatitis C virus infection, but it is clearly a cause for grave concern.

As more women survive into old age, the role of gender differences among older adults will become more important. South Asian women experience greater ill health and a loss of activities of daily living as they age.[48] They are also more vulnerable because they are likely to be illiterate, unemployed, widowed, and dependent on others.[49] The combination of perceived ill health and lack of support mechanisms contributes to a poor quality of life, and public policy to address the concerns of this group of women will be needed as increasing numbers survive to old age.

Dealing with health and gender

Most gender based health differences in South Asia can be traced back to the same underlying factors: decreasing fecundity and consequently a preference for sons, spread of the practice of dowry across most groups in the region, and the marginalisation of women in agriculture. We believe that all of these factors are tied to the perceived lack of economic utility of women. Current societal circumstances make the cost of having a daughter so high that families may be unwilling to invest scarce resources for their benefit. Similarly, the scarcity of resources causes society to undervalue women, who, as a rule, are not making a visible economic contribution. Attempts to address gender disparities must take into account these underlying issues. However, education and improved economic circumstances alone are likely to be insufficient to change practices that have become culturally, socially, and in some cases legally, enshrined. Programmes and policies aimed at reducing differences at the level of education and employment between men and women must enshrine gender equity as a core value. In this respect Sri Lanka might be considered a role model for the rest of South Asia—minimal gender differences in education and employment levels in Sri Lanka lead to a life expectancy and healthy life expectancy equivalent to those of industrialised countries.

In this sociocultural context, the violation of fundamental human rights, and especially reproductive rights of women, plays an important part in perpetuating gender inequity. It is therefore imperative that a rights based approach be taken across all developmental activities in South Asian countries.

Conclusion

The life advantage for girls and women that is seen in health statistics in industrialised countries is blurred in South Asia where gender—based on social, cultural, and, in some cases, legal constructs and practices—overrides the biological advantage of being born female. Policy makers, programme managers, health professionals, and human rights workers in the developing world and especially in South Asia need to be aware of and responsive to the detrimental health effects that gender plays throughout the life cycle.

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Importance of health research in South Asia

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South Asian countries face similar health problems and would benefit from collaboration in health research

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Research is essential to guide improvements in health systems and develop new initiatives.[1] South Asia has a quarter of the world's population, weak public sector health care, and a staggering disease burden, and thus research is particularly important. Although investment has increased in infrastructure for health research over the past decade, gaps remain in evidence to guide reduction of important problems such as communicable diseases, maternal and perinatal conditions, childhood diseases, and nutritional deficiencies.[2] Furthermore, even when technical knowledge is available, political commitment, managerial competencies, and incentives for changing behaviour within health systems are often lacking.[3–5]

One region, eight countries, complex challenges

Despite diversity in their geographical, linguistic, and political structures, Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka face common health challenges. Most bear a triple burden of persisting infectious diseases, increasing chronic conditions, and a growing recognition of injuries and violence. Incomplete demographic transitions, HIV and AIDS, massive unplanned urbanisation, and a host of social determinants of health compound these problems.[6] Another common characteristic is that national estimates of health mask large variations within countries (fig 1).[7 8]

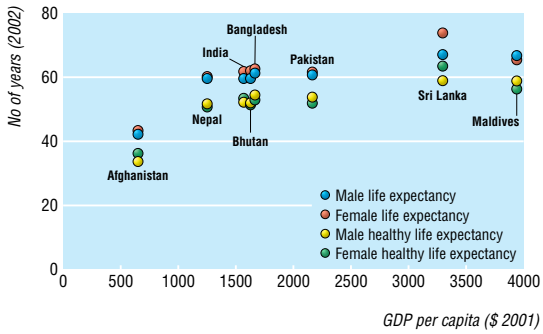

Fig 1 Life expectancy and healthy life expectancy by gross domestic product per capita[9]

Health systems across the region also have to confront challenges such as a lack of evidence based policies and limited social accountability. With no or limited national health insurance schemes and the large role of the private sector, individuals face high out of pocket payments on top of other economic and social consequences of ill health (fig 2).[10] In many countries, the devolution of financial responsibility for health services has outpaced capacity and decision making authority, contributing to fragmentation of policies and services.[11] Striking inequities in the provision of human resources, infrastructure, and effective services abound between regions of countries, socioeconomic classes, and rural and urban areas.[8]

Health research and health system challenges

A systems perspective[12] is required to understand how research and knowledge from various sources is produced and synthesised, how the demand for relevant knowledge is cultivated, and whether that knowledge is used to strengthen the effectiveness of health systems,

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