A Gendered Reality

An Overview of the Health Sector in South Asia

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Abstract

The issue of gender and health is inextricably linked in shaping the life choices of women and girls. Addressing the issues of women, gender, and health inevitably requires the study of the health situation of women and girls -- and men and boys – throughout the life span encompassing areas beyond sickness and diseases. It also includes the study of gender and gender inequality in relation to individuals' health seeking behaviour, the physical, economic, and social conditions in which they live, role of norms and values, cultural attitudes and belief system in their everyday life, their ability to promote the health of their families, their communities, and themselves. With this focus in mind this paper explores the literatures particularly concentrating on gender and health issues in South Asia. The paper will largely look at both quantitative and qualitative studies and researches from secondary sources looking broadly on three countries in South Asia, i.e. Bangladesh, India and Sri Lanka (including Pakistan to some extent). The main emphasis here is to specifically delve into the area of gender and health, probing at intra-household investment decisions and gender disparity in food intake and nutritional disparities, role of custom, traditions and age old cultural practices in shaping the options and choices, access and rights available to women and girls compared to men and boys. The article reveals the impact of gender inequality in determining the health outcomes like anaemia, stunted growth, child and maternal mortality, maternal morbidity etc. for women and girls in South Asia.

Key Words: Gender, health, intra-household disparity, South Asia

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Introduction

Incredible Progress yet Persisting Inequalities

Today's world has experienced incredible progress in terms of combating hunger, ensuring access to good health, access to pure drinking water and sanitation, education, establishing human rights and dignity. Immense progress has been made in communication technology and scientific innovations. The world has become small and at the same time has grown into an inconceivable shape and form which was simply unimaginable even in recent past. However, this global whole is not without its edges. The progress was not even for all. Deprivation, discrimination, subordination, marginalisation, disparity and unequal social, political and economic relations between countries and regions, cutting across gender, class, ethnicity, race, religion, disability, age and sexuality is persisting.

World Food Programme (WFP) in 2016 reports that every year 795 million people in the world continue to go to bed hungry each night and do not have enough food to lead a healthy active life. The vast majority of the world's most hungry people live in the developing world. Asia is the continent with the two thirds of the total hungry people and Sub-Saharan Africa is the region with the highest prevalence of hunger. It's often the youngest and the women whom are hurt the most. As of 2015 ninety million children under the age of five are underweight. Living in chronic hunger and malnutrition puts children at risk of dying from common cold and infection. Stunted growth is even more common than underweight. Globally 160 million children have inadequate height due to chronic hunger and malnutrition. Gender disaggregated analysis of these data often reveals disproportionately unequal treatment of girl child, girls and women compared to boys and men. Unequal gender relations, gender disparity and secondary position of women have been a concern for decades for the academicians, activists and development workers all over the world. This paper is engaged in exploring the paradox of gender inequality amidst inconceivable progress and abundance in the context of South Asia.

Anthropological evidence shows that egalitarianism was one of the primary features for the longest period of human civilisation. Disparity and discrimination started to institutionalise and strengthened itself in the history of human civilisation only in recent past (10,000 years ago from the present) (Kottak, 2000). Enormous progress and development come along with a package of human deprivation, contradictory indicators, ensuing a complex and ambiguous scenario often hard to summarise is a neat wrap. Under the circumstances with changing development situation, persisting inequalities, particularly gender inequalities remains as one of the most crucial challenges for ensuring development for all. Against this backdrop, this paper tries to locate these loopholes with special emphasis on gender and health in South Asia.

Among all the marginal groups, gender inequalities that exist between men and women, boys and girls demand special attention. Gender marginality and women's position in the broader discourse of gender is critical as it is not directly linked with the number or majority/minority issue like other oppressed sections of the society. Gender disparity is not simply correlated with income poverty. Many studies have shown that often there lies little

correlation between per capita incomes. Gender disparities in health or education outcome have often been found to be having hardly any direct association with GDP (Filmer and King, 1999). The inequalities also have more 'finer' dimensions like freedom, personhood, dignity, mobility, autonomy, choice and options, space to express ideas and orientations, rights and access, decision-making capacities in relation to allocation of resources and ability to control one's own body and life choices. Many of these human rights and choices are denied to women even in many developed countries.

Gender inequalities can be ever pervasive, embedded in major social institutions of the society and culture. However, it stems from the household or in other word, family – the oldest and most persisting social institutions in the history of human civilisation. Family and household come with a package of material and non-material activities, expectations and ideologies which are rooted in social norms and values, often fuelled by religious norms and sanctions, patriarchal mind set—fossilised and rigid, creating unyielding boundaries, perpetuating and reproducing the same old deeply entrenched rules of the game where women are considered as secondary.

Patriarchy—the most rigid and inflexible ideology, pervades all institutions, reinforcing both formal and informal arenas of everyday lives, manoeuvring access, control, choice and options, freedom and mobility, rights and power, determining the position of women within the society. Gender disparity, in particular, is related to human psychology, people's mind-set, long lasting habits and most importantly internalisation and perpetuation of patriarchal values both by men and women. Patriarchy a system embedded in household and family stretching itself to formal and informal institutions and organisations, policy-making bodies and ideological discourses creating an unending chain of gender deprivation and inequality across generations. Exploration of intra house-hold scenario thus becomes imperative to the understanding of the paradox of development and persisting gender disparity in the area of health in South Asia.

Focus of the Study and Methodological Concern

While looking at the gender disparity at large, this paper explores the literature and secondary sources of data particularly focussing on intra-household gender situation in South Asia. The paper have seen both quantitative and qualitative data and researches from secondary sources focusing broadly on three countries in South Asia, i.e. Bangladesh, India and Sri Lanka (Including Pakistan to some extent). The focus here is to look at the disparities within households between men and women as well as boys and girls and analyse its short term and long term impact creating intra-generational and inter-generational inequalities and differences of capabilities and opportunities. The main areas of concentration will be limited to issues related to health. The key purpose is to look beyond simple money matrix and economic factors and delve deeper into comparatively less explored areas like intra household allocation and distribution pattern of resources, to excavate the impact and influence of norms, values and practices upon gender relations with particular focus on health.

As mentioned above, the study is based on secondary sources on intra household data on gender. Available literature on intra-household data and narratives are not uniformed in

nature and also could not be captured under single time line across countries. However, a snapshot (mostly ranging from 2010 to 2015) view has shown both positive and negative dimensions of issues related to health and gender revealing the paradox of developments, with all its surprises, bottlenecks and barriers seeping into exclusion and deprivation. Human Development Indexes for the last 25 years have been immensely successful in revealing the fact that mere statistical data and information related to growth and production is not enough to explain and understand the 'richness of lives', human wellbeing (HDR, 2015), livelihoods, human potentials and choices. Gendered exclusion, marginalisation, deprivations and boundary setting are deeply rooted in social and cultural factors embedded in values, norms, religious sanctions and barriers and these are not always reflected in quantitative macro data alone.

In order to capture these critical issues which are often unquantifiable— requires tapping of qualitative research and insights to understand the inner dynamics of intra-household gender disparity. This paper will embark upon secondary sources of both quantitative and qualitative research findings to speculate the scenario of gender deprivation and to outline tentative suggestions to overcome the barriers and exclusion. Despite the importance of quantitative data on gender issue one must admit that qualitative data are and analysis is critical to the understanding of gender issues.

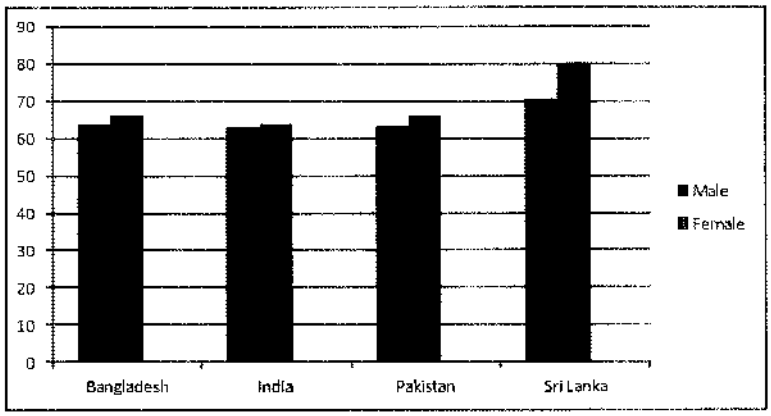
Qualitative exploration, in-depth case studies, although not representative and often makes it difficult to reach a generalised conclusion, but very crucial in revealing layers of reality and everyday experiences otherwise blurred in macro data. Invaluable insights can be drawn to illuminate the intricate power relations between men and women shaping human capacity, access and control through qualitative data. However, the process and the outcome of these data is complex, often contradictory and ambiguous and challenging. Despite the ambivalence, qualitative narrations are critical in revealing the nuances of human lives enriched with indications towards a forward-looking journey, exploring new issues, new indicators, new horizon, new methods and techniques for further refinement, emphasizing quality of human development in addition to its quantity. The paper will specifically look into the area of gender and health, probing at intra-household gender disparity in food intake and nutritional status, anaemia, access to health facilities, child and maternal mortality rates, maternal morbidity, nutritional disparities, intra-household investment decisions and health outcome etc. by exploring the existing literature.

Gender and Health: A Multi-Faceted Issue

Over the last two decades indicators related to gender disparities and health issues are many, ranging from life expectancy, infant mortality rate, birth weight of babies, prevalence of child malnutrition, maternal mortality rate, prevalence of anaemia among pregnant women, pre and post natal access to medical facilities, antenatal care coverage including broader areas of access to safe drinking water, sanitation, immunisation, institutional responses, so on and so forth. This section would like to ponder upon some statistical data (based on national data/statistics) on the above criteria in order to reveal the gender dimension of health status in South Asia at a glance, followed by qualitative analysis from secondary sources.

Longevity, Life and Livelihoods

Graph 1: Life Expectancy at age 70, 2009



Sources: Compiled by the authors, 2016

The gender disaggregated data presented above clearly shows the comparative advantage of female over the male in terms of life expectancy at the age of 70. Sri Lankan women have scored the highest compared to Bangladesh India and Pakistan.

However, this data needs to be complemented with qualitative data exploring the status of elderly women in these countries. What does it mean to have a long life? What are the livelihood options and opportunities, access and rights of elderly – what is the quality of life entailing with a long life (compared to male counterpart) in South Asia?

As more women survive into old age, the role of gender differences among older adults becomes critical. South Asian women experience greater ill health and loss of activities of daily living as they age. In most of the cases, they are illiterate, unemployed, widowed and dependent on others.

A study on elderly people of Dhaka, Bangladesh slum (Mannan and Banu, 2016) denotes that due to the age gap between male and female spouse, most of the elderly female are either widowed, single or abandoned by their male partners. While the male partners are mostly with their wives (may be second or third), enjoying the support of female partners much younger than themselves during their old age. In some cases more than one woman from a single marriage can be pushed into such situation in the context of polygamy. Female elderlies across class situation mostly live in isolation, and neglect — compared to their male partners. Poor female elderlies are in even worse condition, denied of any monetary or material safety net as well as medical and psychological support. Access to health facilities or state support, however meagre is a great challenge due to their medical condition, old age and disability. In the absence of formal structure like old homes and state support, including specially catered medical support; the issue of longevity, particularly for female elderly becomes a contentious issue. With the advent of increased rate of urbanisation, rural to urban migration, slum dwellings, and urban household structure —the scope to accommodate the elderly is often limited. The traditional social role of *'Murubbi'* or respected elderly has also gone under enormous changes and shifts in urban context where elderly, particularly female

elderlies have little or no social utility or respect. Moreover, in many cases, elderly females are engaged in care work of their grandchildren and thus bearing the burden of increased workloads and responsibilities which is unpaid. Reproductive roles of women at large perpetuate their dependency on their children or other family members.

Social and cultural norms those are prevalent in South Asia put women (here elderly women) in a vulnerable situation and thus higher life expectancy is often challenged from the perspective of quality of life, well-being, right to enjoy life with honour and dignity, happiness with a sense of worth. On the other hand, with the increased rate of elderly in the demographic scenario children are also burdened with the responsibility of looking after their parents. Again it is the younger women in the household who bear the responsibility of the care work of old and disabled which is unpaid and unrecognised. Mere statistical data showing higher life expectancy may not be enough to explain the quality of life and wellbeing of elderly in South Asian context. More in-depth qualitative research and exploration on intra household division of labour, resource allocation and distribution of both tangible and intangible resources, increased option and choice, autonomy and personhood—can reveal areas for intervention in ensuring a life of dignity, self-respect and self-esteem with particular focus on old age. State level policy interventions especially designed to address the multiple issues ranging from physical, psychological and social and cultural notions and values related to old age is important.

Reproductive Health

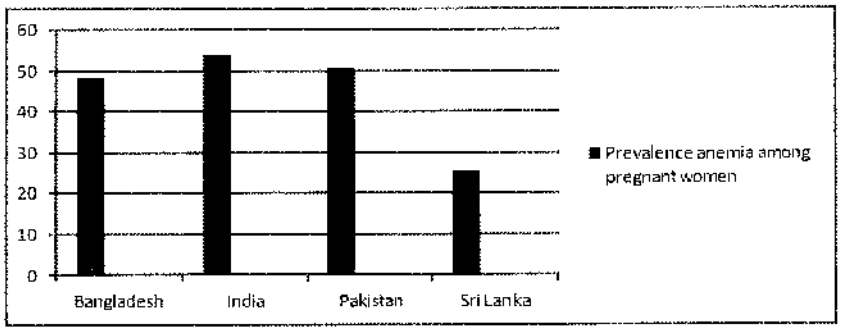
Health issues are not merely related to illness and diseases but encompass a myriad of notions and practices informing and influencing the domain of health and wellbeing.

The nature and incidence of diseases vary among societies. Different cultures interpret and treat illness differently. Standards for sick and healthy bodies are cultural constructions that differ in time and space. All societies have health care systems, either formal or informal. This consists of beliefs, customs, norms and values, techniques and responses of preventing and curing illness. Gender and reproductive health issues are at the crossroad bridging both biology and social construction which play a profound role in shaping the state and status of women.

In most of the South Asian Countries, health care seeking behaviour of mothers varies across culture. Over and above the maternal mortality rate, pregnancy itself, prevalence of anaemia, lack of adequate nutrition, rest and leisure, age of the mother, mother's weight, diabetes, depression or mental or psychological problems, maternal morbidity, births attended by skilled health professionals are crucial factors during pre and antenatal stage. In many of the South Asian countries, pregnancy and giving birth is usually considered to be a 'natural' phenomenon and is believed to be requiring no extra attention to ensure a safe delivery (Akhter, 2015). Maternal health outcomes are dependent upon a complex interaction of factors at various levels, such as government's policies and actions, access to the health care system, service delivery, distance of the health care centre, transport and infra-structure, financing, decision making capacities, asset access and most importantly ideologies related to women's body and birthing dominating the structure of households and communities.

This leads us to the general health situation of a mother in South Asian context with far reaching implications. Following graphs will shed light into the complex web of gender and health issues.

Graph 2: Prevalence of anaemia among pregnant women, 2011



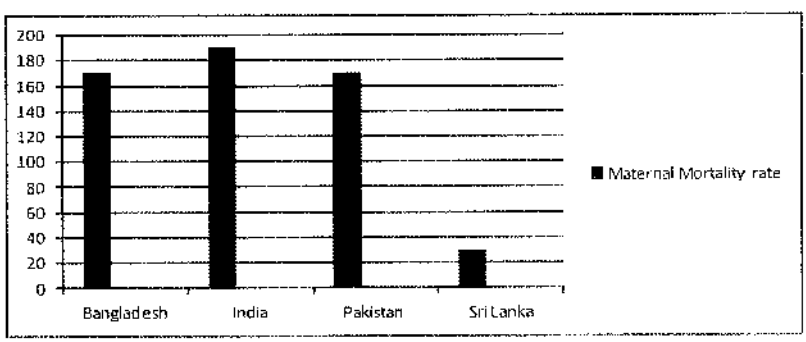
Source: World Health Statistics, (2015)

Prevalence of anaemia is closely related to maternal and child health. According to the above graph, except for Sri Lanka, more than 50% pregnant women are anaemic in South Asia, with the highest percentage in India. Pregnant women who are anaemic are at higher risk of maternal mortality and morbidity. The result would only perpetuate a generation of underweight children with lower life expectancy and stunted growth. The impact of the pregnant mother suffering from anaemia denotes malnutrition at the household level spilling over to the next generation of ill health children.

Maternal Mortality vs. Maternal Morbidity[1]:

Literature on gender and health are overwhelmingly biased towards rate of maternal mortality. Despite the fact that Maternal Mortality Rate (MMR) is crucial to human development but the issue of morbidity is even more important to reveal the status of gender and health issue.

Graph 3: Maternal Mortality Rate (per 1000 live births)



Source: Compiled by the Author[2]

1. This section heavily draws from the Ph.D thesis of Akhter, S., (2015)
2. Source: WHO, UNICEF,UNFPA and The World Bank estimates, (2014)

The above graph shows the comparative advantage of Sri Lanka. Sri Lanka has significantly lowered its rate of maternal mortality, which is an indicator of greater gender equality. Bangladesh and Pakistan has fared better but India is lagging behind compared to Bangladesh and Pakistan.

However, maternal mortality is often regarded as the 'tip of the iceberg.' Akhter in her Ph.D. thesis (Akhter, 2015) mentions that for every woman who dies of pregnancy related complications, 20 to 30 others experience acute or chronic morbidity often with permanent health damage that can affect women's physical, mental, sexual or productive and reproductive capability. Moreover, unlike maternal mortality, no time frame for maternal morbidity can be set, as it can occur and continue throughout a women's life span (Bhatia and Cleland, 1996).

Maternal morbidity can range from severe bleeding, anaemia, pelvic inflammatory disease, damage of reproductive organ, fistula, genital prolapsed, uterine rapture, nerve damage, chronic hypertension, kidney failure, complications in future pregnancy and much more. In most of the cases maternal morbidity is caused by birth not attended by trained mid wife or *'dai'*. Fistula or other post-delivery injury occurs during the first child birth and continues to affect the health of mothers for years. The second birth or third can only perpetuate the state of morbidity. The impacts of these are far fetching. Maternal morbidity will affect the health condition of mothers as well as their children, families and finally the entire country. Most of the health programmes are aimed at reducing the number of maternal mortality but the maternal morbidity is often ignored. Treatment seeking behaviour of mothers is also largely shaped by the secondary position of mothers and women within the household. The most important indicators of the status of women which have the potential to improve health status are education and women's access to income earning. Many studies have already revealed that education, access to property and resources, participation in income earning activities and gainful job, access to knowledge about opportunities, control over their own body and sexuality are critical to improving health condition of women. There lies a positive association between women's education and nature of treatment sought for childbirth complications and post-partum illness.

As it was mentioned earlier that maternal morbidity is also ignored in discussions in research and policy programmes. Maternal morbidity issues are left out of routine health care activities especially in South Asia. Maternal morbidity thus remains as marginal to the entire domain of gender and health (Akhter, 2015). Research shows that in spite of the remarkable decline in the MMR in Bangladesh over the last decade, as many as 76.6 percent of mothers still deliver their babies at home. MMR during pregnancy has declined by 50 percent (between 2001-2010), while maternal mortality during the post-partum period (i.e., within 42 days of delivery) was reduced by only a third (Akhter, 2015). In Bangladesh post-partum maternal deaths now account for a higher proportion of maternal death, which is 73 percent in 2010 compared to 76 percent in 2001(NIPORT et al, 2012).

Women's socio-economic status has always been considered as one of the most influential factors in shaping the area of maternal health. In fact, this behaviour reflects the socio-economic status of women ranging from ability, control and right over spending money on health care, making an informed decision or choosing to go to a hospital for treatment (WHO 1998). Maternal morbidity is entwined with women's empowerment, social norms

and values, the culture of shame and silence and negligence— with her entire existence and positioning as a woman in the community.

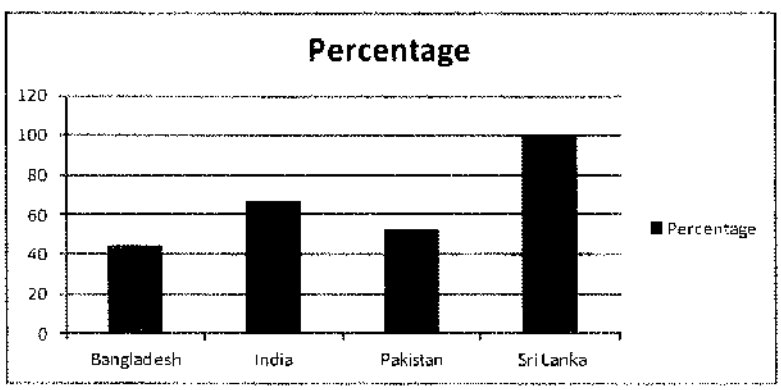
> *"In our village there are lots of hard work. I had six normal child deliveries. After the birth of the fourth child, this (fistula) happened. I had to work hard after she was born. I had to cook food for 10-15 kilo rice, had to carry 20 jars of water. I brought up younger sister in law and also many other jobs. Can't tell you how many".* (Akhter, 2015:149)

Birth Attended by Skilled Health Professionals

Birth attended by skilled health professionals is another crucial indicator to measure the maternal health issue. In depth research (Fikree and Pasha, 2004) states that women often cite economic circumstances and spousal or familial opposition to delivery in the hospital as the most common reasons for delivery at home. Decisions about seeking care are made largely by the husband or the elder members of his family. Distance of medical centres and lack of good communication, infra-structure and transport are other reasons for fewer numbers of women visiting the health centres in South Asia. The issue of MMR and Maternal Morbidity is also closely related to medical health issues and ante/pre-natal care system and the attitude towards modern health facilities. Over and above the economic reason, fear and apprehension about modern health facilities for child delivery, culture of silence and shame, mistrust against medical services and quality of the services also circumvent the health seeking behaviour of women.

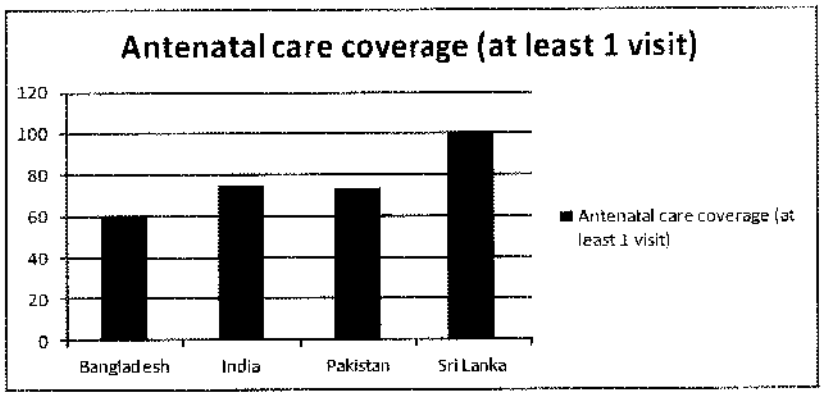
> *"...We will die, but we will not go to hospital for delivery. There, I heard, male doctors do this (CS). I know, female doctors deliver the baby but male doctors remain with them. Is it not a matter of shame,..? If any trouble happens, can a female doctor handle that? She will call a senior male doctor. People say that if we go to hospital for delivery they will do something that we will never be able to have any more babies. You know, the Government asks us to have fewer children, that's why they do something during delivery. We heard about this from people around us."* (Akhter 2015: 133)

Graph 4: Births attended by Skilled Health Professionals Percentage, WHO Statistics, 2015



Source: World Health Statistics, (2015)

Graph 5: Antenatal Care Coverage (at least 1 visit)



Source: World Health Statistics, (2015)

According to Graph 4, Sri Lanka again is found to be 100 successful in ensuring births attended by skilled health professionals while in Bangladesh and Pakistan more than 505 women on average remains outside this service. India has managed to bring one-third of births under skilled health professionals. Antenatal care coverage has achieved better score compared to the indicator of birth attended by the skilled health professionals at large. Nevertheless, it also reveals that on an average, except for Sri Lanka around 30 percent pregnant women remain outside the coverage of at least one visit during their pregnancy (Graph 5).

In Bangladesh only 37 percent births take place in hospital. In 2014 presence of midwives during delivery was 42 percent (*The Daily Prothom Alo*, 2016). It has been proved in many cases in South Asian countries that maternal mortality and morbidity can be reduced in a great extent just by ensuring presence of skilled birth attendants during delivery. However, putting too much emphasis on *dai* is also problematic. The notion and perception around childbirth, its association with shame and silence may lead to complicacies even in the presence of a 'skilled' birth attendant in rural Bangladesh.

> *".. I have been doing this (working as birth assistant) for the last 20 years. I myself don't know which way the baby comes out. I mean I have never seen. I always cover the mother's body with a big chador (wrap) and try to feel the baby using my hand. But in hospital, everyone sees, doctors, nurses, and other hospital people. You cannot keep your 'somman' (honour) if you deliver at hospital.* (Akhter, 2015:135)

Monitoring the activities, expertise and role of *dai* is another area that should be pursued upon with immediate urgency. According to a respondent in the rural areas of Bangladesh, the *dai* tried to pull the baby out manually, tearing the area and creating a hole and the mother (Jahanara) states,

> *"I got married at the age of 13. I got pregnant two years later. I went to my parents' house for delivery. Then I had 'Gorbhotonka' (convulsion). The convulsion was so much that the baby's head could be seen at my cervix. Then the dais, who were present there, thought the baby should be born right then. Then they tried to pull out the baby using their hands. But*

> *the baby did not come out. It died inside. I stayed conscious for the following three days. Then my family took me to the district hospital. They brought the baby out by cutting a bit in the cervix. I think , ...my bladder got somehow cut at that time. Soon I realised that my urine is coming out without any control. When I tried to stand up, faeces came out too."* (Cited in Akhter, 2015:188)

Abortion is another issue related to morbidity of women. *The Daily Prothom Alo*, dated May 13, 2016 illustrates that one in every four pregnant women goes for abortion in the world. Which means more than 5.5 Crore[3] pregnant women in the world are going for abortion, says WHO and Gutmachar Institute published in The Lancelot, UK. This rate is highest in developing countries. This may have long term health impact on women and on her reproductive health and on future generation of children; as most of the abortions in South Asian Countries are performed in unhealthy, non-medical situation with unskilled hand and in situation of undercover. Abortion is illegal in most of the South Asian Countries. Legal reforms are often helpful to push forward an issue despite social, cultural and religious resistance.

Sexual and Reproductive Health and Rights (SRHR) Issues

The issues of rights and access to resources are also of crucial consideration. The recent jargon around SRHR issues has drawn attention to the right based approaches to tackle health, particularly reproductive health issues. The violation of fundamental human rights, especially reproductive rights of women, plays an important part in perpetuating gender inequity. SRHR is the concept of human rights applied to sexuality and reproduction (Mathur, 2016). SRHR encompasses the right of all individuals to make decision concerning their sexual activity and reproduction free from discrimination coercion and violence. Women and girls' health, mortality and morbidity, freedom, choice and right issues are inextricably linked with SRHR discourses.

Services and rights around abortion is another critical area in relation to SRHR issues. Despite considerable efforts over the past 20 years, maternal mortality is still very high in the world. Unequal power relations within the house hold, women's empowerment and women's rights issues are also linked with this rate. Unsafe abortion in a context where abortion is illegal and high price is placed upon women's virginity and purity, unsafe birth and associated complicacies like fistula, anaemia, high blood pressure, gestational diabetes, lack of knowledge and information regarding SRH, all are part and parcel of women's secondary position and lack of control over her own body and sexuality. Gender issues are often interconnected and interlaced with issues related to other sections of the society. Specially ensuring rights to women's body and sexuality can influence areas which are apparently incomprehensively (Levitt and Dubner, 2005).

If human development is all about expanding the scope of choices then creating opportunities to make free, fair and lifelong choices with transformatory potentials are of critical importance. In the socio cultural context of South Asia, violation of human rights, and especially reproductive rights of women, plays an important part in perpetuating gender inequality. It is, therefore, imperative that a right based approach be taken up seriously. In addition to limitations in physical health care— psychological health situations of women and mothers are another area which has far reaching implications for the children. Lack of

3. Million

recognition and provisions to address mental health of women and mothers may turn out to be a major problem in near future (Ambramson, 2012).

Menstruation, another important part of female reproductive cycle which plays critical role in relation to SRHR issues. Menstrual health is fundamental to women's sexual and reproductive health. Menstrual dysfunction in adolescent girls may affect normal life of adolescent and young adult women. Social and cultural stigma around menstruation, notions related to purity and pollution, perception on bodily image, adulthood, reproductive role including the idea of shame and embarrassment is found to be associated with women/ girls and menstruation. This again shapes the nature of health seeking behavior of girls/women. The connection between menstruation and anemia, malnutrition, poor sexual and reproductive health is common to women/girls in South Asia creating an unending cycle of ill health for women (DOAJ, 2017). Although this paper is not addressing the issue of SRHR with proper attention, it is pertinent to keep the issue of 'right' within the broader loop of reproductive health as a critical criterion for future consideration.

Shaping of Gender: Cultural Norms and Beliefs

Women in South Asia find themselves in subordinate positions to men and are dependent on men both socially, culturally and economically. 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 (sometimes from female relatives/in laws as well). Son preference is another characteristic that has economic, social and religious utility. Daughters are seen as economic liability because of the dowry system (Fikree and Pasha, 2004). Women's subordinate position within the households lead to denied access to care because of cultural beliefs and practices, seclusion and restriction on mobility. Decisions making capacity mostly lies with her husband or on other family members. The distance of the medical centre and lack of access to any resources shapes the opportunity and health seeking behaviour by the pregnant women in particular and women in general. As mentioned earlier, pregnancy and child birth is not viewed as a medical event by the society as well as by the mothers especially coming from the lower socio-economic groups; hence, they are often reluctant to receive or seek care from health facilities. However, it is not only poverty that moulds the treatment seeking behaviour of women. Societal norms embedded within the household and family are important deciding factors. Gender inequalities enshrined in household and in its material and ideological framework lead to systematic devaluation and neglect of women's health. Women themselves are less likely to seek appropriate and early care for diseases. Moreover, research and documentations also lack in measuring the quality of the reproductive health services which might be another reason of not seeking health services even when opportunities are available.

Gender discrimination at each stage of female life cycle contributes to health disparity. Sex selective abortions especially in India and Pakistan, neglect of girl children, reproductive mortality and morbidity, poor access to health care for girls and women lead to greater disparities. According to Zimmerman (2011), in a number of developing countries, girls have significantly worse in education, health and nutrition outcomes than boys. One possible explanation for this discrepancy in child outcomes is gender discrimination in the intra-household allocation of resources. Parents may spend more on boys than on girls, both in monetary terms and in the time allocated to each child. Parents in India may wait longer before going to the hospital with their baby girl than they do with their baby boy, leading to differences in health outcomes.

Maternal Health Determining Child Health: Food Intake, Social Norms and Culture of Eating Last and Least

In the recent past, Bangladesh has increased food grain production from 11 to 39 million metric tonnes. However, mere increase in food production may not be translated in better nutritional outcome in south Asian countries. The traditional family structure across south Asia also breeds forms of social exclusion and deprivation. Women often eat last and the least. As mentioned earlier, that despite the lack of power, decision-making capacities and rights, access and control over property and economic benefits, the household ideology perpetuates the role of altruistic mother and as the provider of food to the children and other members of the household. The mother-child unit thus becomes central to any health interventions in South Asia.

The gender politics of food fuelled and nurtured by assumptions, norms and values of mothers and women needing fewer calories and her role as the provider within the household pushes her into a perpetual status of malnutrition and protein deficiency. Food remains the biggest item in the poor household budget. It is as high as 50 percent in South Asia compared to 17 percent in the United States (Narayan, 2011). In most cases of food deficiency due to price hike— households limit their food intake, with direct impact on the nutritional status of mother and children. South Asia is also the only region in the world where gender disparities are prevalent even in child malnutrition. There is a clear link between food insecurity and gender inequity. Norms and values related to women as the provider further restricts her access to food and nutrition within the household. There are other institutions which are embedded in the socio-cultural practices and household ideologies. Child marriage is another of such institutions with immense implications in women's lives. This brings us to the critical issue of child marriage leading to early pregnancy which is one of the most detrimental factors influencing the health status of both mother and child.

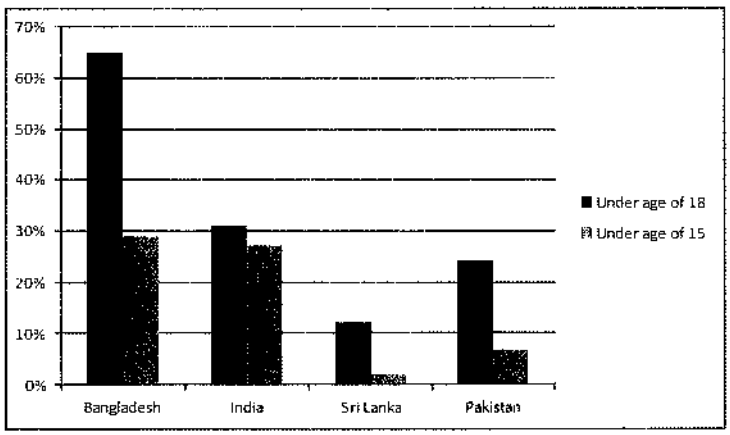
Child Marriage

Child marriage is a global phenomenon. According to Plan International (2010)15 million girls marry before the age of 18 each year – the equivalent of one every 25 seconds. If unattended, more than 140 million girls will become child brides by 2020. Child marriage is most common in South Asia and in West and Central Africa, where 46 percent and 41 percent become child brides respectively. Child marriage— a silent health and human right issue which denies girls' right to make decisions about their sexual health and well-being, leads to early pregnancy and forces them out of education and a life of poor prospects with increased risk of violence, abuse, ill health or early death. Maternal health is also linked with age at marriage and teen age pregnancy. Early age at child birth with immature pelvic and poor nutritional status contributes to obstructed labour and pre and post natal complications.

One of the reasons for this is that young mothers are ill equipped both in terms of physiological attributes and socio-economic factors. In Bangladesh for instance, two-thirds of the girls are married as teen agers. They are often illiterate, malnourished and impoverished and as mothers are more likely to perpetuate the intergenerational cycle of hunger, poor nutrition and ill health (Narayan, 2011). A recent study in Bangladesh conducted by Directorate of Population Control, Government of Bangladesh has revealed that half of

the country's adolescent girls are with stunted growth while 43 per cent are suffering from anaemia (The *Daily Prothom Alo,* November 10, 2016). The report also added that 66 per cent marriage taking place in the country where the age at marriage for the bride is under 18.

Graph 6: Child marriage



Source: Compiled by the Authors.

According to the above graphs and bar graph, Bangladesh has the highest prevalence of child marriages among four countries those have been analysed in this report. Currently, the minimum legal age for marriage is 18 for women and 21 for men– as stated in the Child Marriage Restraint Act 1929 in Bangladesh. However this is poorly enforced and the punishment of either imprisonment of up to one month and/or a fine up to 1,000 Taka (US$13 appx) rarely acts as a deterrent[4].

As usual Sri Lanka has managed to lower its rate to 2 percent to 12 percent both in the cases of 18 and 15 years of age respectively.

It's a development paradox that how Bangladesh could manage to bring down the maternal mortality rate with such high prevalence of child marriage that is 65 percent and 29 percent under the age of 18 and 15 years of age. It is not hard to imagine that teen age pregnancy can cause a vicious circle of maternal mortality, maternal morbidity, and high incidence of child mortality and generations of under weighted children suffering from stunted growth, malnutrition and vulnerability.

Moreover, child brides are often more controlled by husbands and in-laws. It may be that women married as minors are unable to advocate for adequate nutrition for their children,

4. In September 2014, the Cabinet of Bangladesh approved language in the draft Child Marriage Restraint Act 2014 to lower the minimum age of marriage from 18 to 16 years for girls. This resulted in international outcry and delayed the passing of the draft Act for two years. In November 2016, the Cabinet said it would pass the Child Marriage Restraint Act 2016 during Parliament's winter session. The new Act is said to include a special provision allowing child marriage in "special cases", such as if a girl becomes pregnant "accidentally" or "illegally", or where a marriage would protect her 'honour'. There are fears that such a provision would legitimise statutory rape and encourage the practice of child marriage. The Government has begun developing, under the leadership of the Ministry of Women and Children Affairs, a National Action Plan to Eliminate Child Marriage 2015-2021. However, progress on adopting and implementing the plan has been stalled in the face of backlash against recent regressive legal proposals.

in the context of their own limited access to food and other resources. Such insufficient access to food is far more likely to cause health risk for child and mother combined with the limited nutritional reserves stored within the bodies of adolescent mothers. This places their offspring at substantial risk of low birth weight and inadequate access to breast milk. The research suggests (ref cited in footnote, page 20) that the effects of inadequate foetal nutrition and reduced breastfeeding among neonates born to adolescent mothers extend into infancy and early childhood thus maintaining and perpetuating their on-going risk for malnutrition related health problem.

Early motherhood, in India and elsewhere, is associated with increased likelihood of neonatal death and stillbirth, low birth weight infants, and child and infant morbidity and mortality. These disproportionate risks seem to be related to social and health related vulnerabilities among adolescents, including increased rates of poverty, maternal depression, and malnutrition. Lack of education and inadequate access to health care may also account for adolescents' lower use of antenatal care, skilled delivery care, and complete infant vaccination schedules.

According to Wall (2006:1, 206)

"The likelihood of obstructed labour is increased in areas where early marriage and childbearing are common, because although growth in height stops or slows with the onset of menarche[5], the capacity of the bony pelvis normally continues to expand after the epiphysis[6] growth plates of the long bones have fused. These problems are worsened if girls have been undernourished throughout childhood and adolescence. Thus, although girls are capable of becoming pregnant at a relatively early age, their pelvis do not develop their full capacity to accommodate childbearing until much later, and many will have their lives destroyed by obstetric injury before they have even crossed the threshold into true adulthood".

Although adolescent motherhood certainly has a substantial role in maintaining the high rates of child and infant mortality in South Asia, it is unclear whether this is truly a consequence of early marriage. This might be one of the reasons behind the paradox of high rate of child marriage and comparative lower rates of child mortality.

While exploring the associations between maternal child marriage (marriage before age of 18) and morbidity and mortality of infants and children under 5 in India, the above research by Wall (1998) informs that the majority of births (73%) were to mothers married as minors. Although the study by Raj (2010) found significant associations between maternal child marriage and infant and child diarrhoea, malnutrition (stunted, wasted, underweight), low birth weight, and mortality—only stunting and underweight remained significant in adjusted analyses. No direct effect of maternal child marriage on health of boys versus girls was found. Thus it was concluded that the risk of malnutrition is higher in young children born to mothers married as minors than in those born to women married at a majority age but child mortality was not found to be directly related to child marriage.

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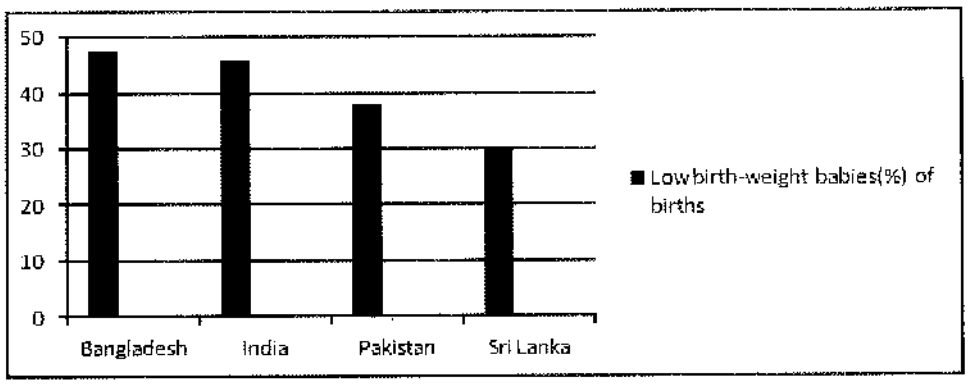
5. First menstrual cycle
6. Rounded end of a long bone, and its joint with adjacent bones in pelvic area.

However, adolescent girls are more likely than those marrying in adulthood to remain poor, uneducated, and within rural communities, and to have low access to health care, all factors that contribute to increased risk for infant and child morbidity and mortality. Furthermore, women who get married and begin childbearing at a younger age are also more likely to have a greater number of children, which is also linked to increased likelihood of poor maternal, infant, and child health outcomes.

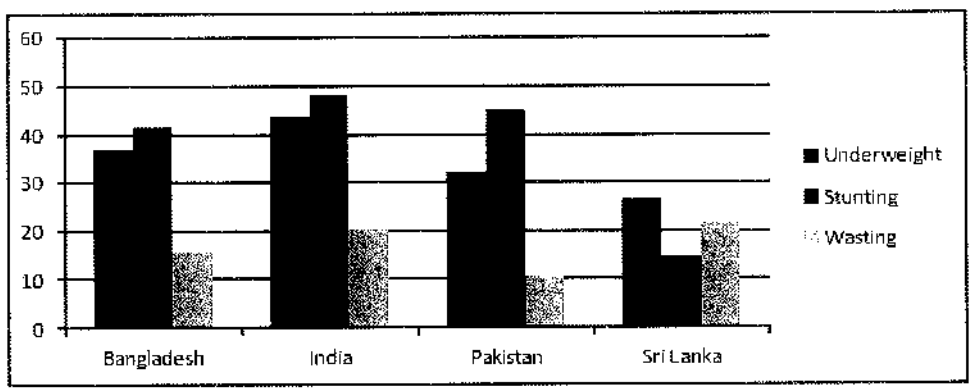
Graph 7: Low birth-weight babies (Percentage) of births 2000-2005



Source: State of the World's Children, (2015).

Despite the fact that Bangladesh is the only country in South Asia which has been successful in reducing child malnutrition from 56 to 43 from 1996-2009 (Narayan, 2011) more than 45% children in India and Bangladesh are still born underweight. Apart from Sri Lanka, Pakistan has 'surprisingly' managed to lower it down to around 39%.

Graph 8: Prevalence (Percentage) of Child Malnutrition <5 years

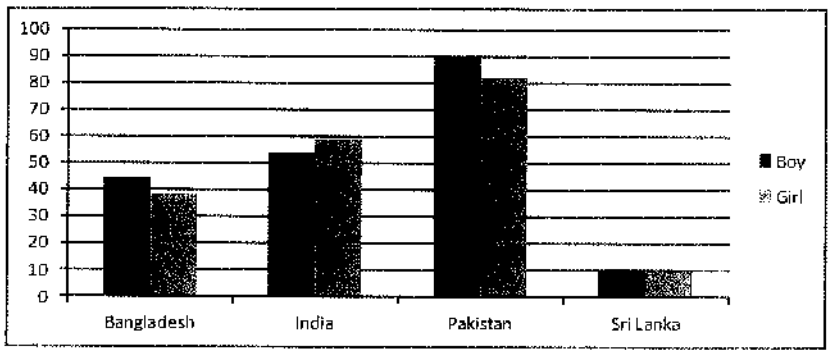


Source: World Health Organization, (2015).

Child malnutrition is another area which is as important as the nutritional status of the mother. The above Graph from different sources shows the correlation between underweight children and their growth in later years of childhood hampered by stunted and wasting

growth. Lactating women and children are the most vulnerable and have special nutrition needs. Young children need to be fed several times a day and the first two years offer a critical window of opportunity (Narayan, 2011). Mothers, especially young mothers suffering from malnutrition are often not in the situation to ensure breastfeeding. The ideology of son preference may lead to further neglect of girl child creating the cross generational chain of deprivation and gender disparity. Too much concentration on mortality rate can be self-defeating. Calculating infant mortality rate is critical but not in ends itself for human development. Quality of life in terms of sustainable health situation and other factors like opportunities, capabilities and access is as crucial as ever for both the mothers and children.

Graph 9: Infant Mortality Rate (per 1000), 2015



Source: State of the World's Children, (2015)

The Graph (No. 9) shows the comparative advantage of girls over boys in terms of mortality rates in case of Bangladesh and Pakistan. With Sri Lanka, the gender disparity and the overall percentage are lowest. However, in South Asia gender relations are based on social, cultural and in some cases legal construct and practices which overrides the biological advantage of being born female.

Intra Household Disparities and Allocation of Resources:

Apart from the other issues mentioned above, girls are neglected at all ages in south Asia. This has led to gender based health disparities among the population aged less than five years that are larger than anywhere else in the world. A girl between her first and fifth birthday in India or Pakistan has a 30-50 percent of higher chance of dying than a boy. This neglect can take the form of poor nutrition, lack of preventive care and delays in seeking health care for diseases (Filmer and King 1999).

As reviewed by Seth (1997), many empirical studies on disparities in the intra-household consumption of non-food resources also focused on the consumption of health and education inputs. While looking at countries like India, Pakistan, Bangladesh and the Philippines, except for the Philippines, a pro-boy bias trend was revealed in the context of health and allocations. Areas cited for the pro-boy bias are related to duration of breast-feeding,

quantity and quality of health care, and survival probabilities after diarrheal episodes etc. all of which are reported to favour boys. Indeed, in India and Pakistan, breast-feeding duration is longer for boys, partly because there is less urgency to have another child after a boy. In Nepal, mothers were more frequently concerned about the adequacy of their milk for boys. In Pakistan, lower income households, sought health care more often for boys than for girls, and were likely to use higher quality providers for boys, although this difference in frequency and quality of care disappeared as income increased (Seth, 1997).

In his Ph.D. thesis, Aminur Rahman (n.d) titled 'Household Behaviour and Intra-household Resource Allocation: An Empirical Analysis', discusses the intra-household resource allocation issues related to nutrition and food distribution, nutrient demand, and child health and nutrition outcomes in rural Bangladesh. Using a measure of bargaining power—spouses' assets at marriage— that is culturally relevant and (weakly) exogenous to household decision making process, finds strong evidence of intra-household bargaining on nutrient allocation and on distribution of food from relatively expensive sources. In this regard, the study found that a wife's bargaining power positively affects the allocation of the adult females at the expense of that of adult males. Spouses' preference and bargaining power also tend to vary at different income levels. Rahman illustrates that at the low income level, a wife prefers pre-schooler boys to pre-schooler girls while the pre-schooler girls to pre-schooler boys at the middle-income level in intra-household food distribution. Son-preference in intra-household food distribution is also guided by cultural norms and appears to be prominent in non-poor households as opposed to poor households in Bangladesh. According to Rahman, calorie intake appears to be highly inelastic for both poor and non-poor while both the macro and micronutrient intakes of the poor compared to that of the non-poor are more responsive to implicit macro and micronutrient prices. These findings have important implication in terms of malnutrition, food policy, and human capital formation in rural economy (Rahman, n.d.).

Schmidt (2012) on the other hand in her study on the effect of women's household bargaining power in child health outcome contends that trends in developing economies worldwide suggest that as relative female intra-household bargaining powers improves, consumption preference favour basic needs which promote child welfare. There exists a positive correlation between children in families where their mothers have decision making authority and child health outcome. Empirical evidences for the study reveals that women who enjoy decision making power in the household, especially in the large purchases, are associated with having children with better height-for-age ratios. Both theoretical predictions and empirical findings note the importance of raising female intra-households power and autonomy. This is particularly relevant for the developing countries where there is persistent gender inequality within the household. Schmidt suggests that women's empowerment and promotion of gender equality are key ingredients to achieving sustainable development. Women's inequality as it translates to intra-household bargaining power affects child's welfare, including rates of chronic malnutrition. Enhancing women's status leads to more investments in their children's education, health and overall wellbeing (Schmidt, 2012).

Household is often assumed as an altruistic unitary category a site of cooperation, ensuring wellbeing of all members and all resources are pooled to be distributed equally by the benevolent household head— who is usually male. This view was challenged by many. The alternative approach illustrates the possibilities of conflicting preferences and looks into household decision making process staking place through bargaining and negotiation and is described as a locus of "cooperative conflict" (Sen, 1990). From feminist perspective family and household are to be seen not only as a locus of love, affection and conducive to all but also as a locus of exploitation and conflict with unequal treatment towrads female members of the household. Not all the members are equally equipped to bargain and negotiate for their own betterment within a household context.

Anuradha Seth (1997) in her paper argues that a remarkable consensus was found in various researches on the fact that the following are critical determinants of an individual's ability to negotiate and bargain for a greater share of household resources: size and composition of household, actual and perceived contribution to household, control over income and other fall-back positions. Evidences suggest that there appears to be a (slight) pro-male, pro-adult and (significant) pro-boy bias in intra-household in terms of food consumption patterns in South Asia.

Miller's (1997) review of intra-household food distribution in South Asia also finds that greater disparities and malnutrition are found among the propertied groups and among the more educated. Discrimination against daughters may reflect the additional financial stress on families as a result of dowry and marriage costs, and not from food consumption of the daughter, per se.

Many scholars have noted that when women contribute to household income and retain some control over its disbursement, their bargaining power increases and the nutritional intakes of household members (especially those of children) are more adequate than when women have no control over how household income is spent. This is mainly on account of the fact that male and females tend to spend their incomes in different ways, with women spending on consumption goods for the entire household and men spending a higher proportion on male items (entertainment, cigarettes). Women in a variety of households are more child-oriented in their expenditures has also been noted by studies comparing consumption patterns between male and female headed households (Seth, 1997). Empowerment of women, ownership and control over resources and greater decision making capacity have been found to be positively influencing the health status of children within the household. However, a note of caution is warranted here. One should be careful to note whether this trend on the other hand, is strengthening the 'altruistic' role of women, mothers and wives at the cost of their own health and consumption pattern.

Concluding Comments

While summing up the cross country intra household data on gender and health, it was found that Sri Lanka is doing extraordinarily well in term of almost all of the indicators addressed here. To learn about what made this possible can be beneficial to development

practitioners and policy makers in order to understand the nuances of gender, health and development. Bangladesh has made considerable progress in reducing MMR and in enhancing the status of child nutrition. However, it has to traverse a long way to smoothen its edges of development in the arena of gender and health. Bangladesh was found with highest prevalence of child marriage among four countries analysed here. It's a development paradox indeed that how Bangladesh could manage to bring down the MMR with such high prevalence of child marriage that is 65 percent and 29 percent under the age of 18 and 15 years of age. More research on the area of child marriage, MMR and child nutrition is required to reveal the interconnectedness of the issues at hand.

More generally it was revealed that considerable progress was made in the area of MMR in South Asia but the issue of maternal morbidity and general health status of both women and children remains unaddressed. Anaemia and other reproductive health problems are found to be making negative impact upon infant mortality and child growth and development in the long run. The critical role of skilled birth attendants is found to be very important. It was also noted that the comparative advantage of women in terms of higher life expectancy and longevity are to be compensated by specifically designed health and social security measures.

Certain social norms and cultural practices are found to be detrimental to women's health with far reaching implications, perpetuating disparities across generation. Patriarchal norms and values are a great barrier against women's empowerment, shaping the intra household resource allocation pattern and decisions related to gender and health. It was also found that empowerment of mothers and women, their access and control over resources can make a big difference in the lives and livelihood opportunities of girl children and women at large.

Child marriage has been identified as the most detrimental to both women and girls creating long lasting inequality in the area of health. Failing to address this single factor can lead to a generation of girls and women trapped in the vicious cycle of poor health[7].

One methodological understanding that emanated from this exercise is that gender differentials have layers of inequalities not always demonstrated in numbers. It is apparent from the above review that numbers are important especially for policy making but must be considered as indicative only rather than to be considered in any exact and absolute sense. Numbers may vary due to methodological issues, numbers are easy to manipulate to access political gains and the 'truth' may become distorted, vague and blurred while compiling statistical data and model building. There are nuances, and ambiguities, hidden layers and unseen shades in human lives which are not always quantifiable but have far reaching impact on everyday lives of people and nature. Moreover rigorous comparative analysis of different statistical outcomes is essential to comprehend the picture from a holistic perspective.

It was found that more in depth qualitative data on house hold interaction can reveal scenario otherwise hidden and concealed. The literature reviews also exposed the paradox and

7. Country specific issues like 'missing women' or 'honour killing' have not been discussed here but are to be addressed with special attention and research and policy suggestions should be more catered to identify such specific issues which can be critical to gender justice.

ambiguity around issues related to norms and values, role of religion and heritage in relation to gender and health. Violence and injustice and other forms of discrimination against women largely stemming from the patriarchal socioeconomic system, structure and mind-set of its people are common phenomena in many of the South Asian countries. On the other hand, many of these countries have significant constitutional provision and national and international statutory laws guaranteeing human and fundamental rights and equal rights to women. However, in most of the cases, poor quality of governance and non-implementation of these policies have undermined the constitutional and institutional pledges.

The issue of gender and health is multifaceted, varied and rich in diversity and difference, often hard to encapsulate in one single model and prescription. Gender is embedded in every other social and eco-political institution. One area in entwined with other, influencing and shaping the whole. Health issues are linked with education, while education is interconnected with women's gainful employment and empowerment. Achievement in one arena may collide with other downward curves in development index. Contradictions and ambiguity is part and parcel of many development paradoxes. Dealing with gender is even more contentious where options and choices are hidden more than they reveal, entrenched in relationship of cooperation and conflict, power and subordination, and played out in complex social configurations. Sri Lanka could make it, so did Bangladesh in many ways. The entire domain of gender, health and development is to be seen as a process enshrined in trial and error, tinted with loss and gain, situated in a context – a journey long and difficult but continuously progressing with new concepts, new challenges and new way outs.

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