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Reversing gender inequities in health and economy: Options for the future

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Reversing gender inequities in health and economy: Options for the future

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Abstract

Gender-inequalities in health exist in the Asia-Pacific region disadvantaging three groups, viz: women/girls, sexual and gender minorities and marginalized men. These inequalities are reflected in erosion of biological resilience at birth of females, neglect of sex/gender-specific health needs of these three groups, human rights violations that endanger the lives and health of these three groups, male sex selection at birth and lesser access to health care in the context of privatization. Gender inequalities in economy have an adverse bearing on gender inequalities in health. Equally, gender inequalities in health adversely influence gender inequalities in economy.

Deep-rooted causes of gender inequities in health and the economy in Asia-Pacific can be traced to unequal distribution of power and resources (between women and men, men from privileged and marginalized backgrounds and sexual and gender minorities and heterosexual women and men), unequal voice and agency of the three groups, and weak accountability of power holders to these rights holders. This in turn can be traced to unequal position within social relations and social institutions. Gender inequalities in health, economy and underlying reasons can be seen as vicious spirals.

Gender inequalities in health and economy are worst in South and West Asia, but at the same time China, Republic of Korea, Vietnam, Singapore and Malaysia reflect a skewed sex ratio at birth. In South & West Asia, China and Republic of Korea patriarchy is deeply entrenched.

A combination of ‘rights’ and ‘development’ measures are suggested to reverse vicious spirals leading to gender inequalities in health and economy. From a ‘rights’ lens all governments should sign and ratify without reservations relevant international human rights instruments and optional protocols, pass legislation pertaining to rights of women, marginalized men and sexual/gender minorities to participation, equality, health, and minimum amount of property, and strengthen powers of national women’s and human rights commissions. Government and donors should create mechanisms for reflecting voices of these groups in policies, legislation and practice on gender, health and economy. They should move from cost effectiveness as a criterion for priority-setting to a rights based approach. From a development lens, governments and donors should increase budgets to health and social security for those in the informal sector, integrate gender and health within all economic programs, integrate economic component within health programs, regulate private health sector, engender public health & administration, and improve sex-disaggregated where gaps exist. NGOs should strengthen voice of the three groups.

Key words: gender inequality, health, health care, human development

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome.
ANC	ante-natal care
ARROW	Asia-Pacific Resource and Research Center on Women
BRAC	Bangladesh Rural Academy
BWHC	Bangladesh Women's Health Coalition
CHETNA	Center for Health Education Training and Nutrition Awareness
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIDA	Canadian International Development Agency
DPR	Democratic People's Republic
FAO	Food and Agriculture Organization
FCND	Food Consumption and Nutrition Division
FGM	female genital mutilation
GDOL	gender division of labour
GEAG	Gorakhpur Environment Action Group
HIV	Human Immunodeficiency Virus.
HDI	Human Development Index
HDR	Human Development Report
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development.
ICRW	International Center for Research on Women
IFPRI	International Food Policy Research Institute
IMR	infant mortality rate
IUD	intra uterine device
LGBT	lesbian, gay, bisexual and transgender
LGBTI	lesbian gay bisexual, transgender, intersexual
MAVA	Men Against Violence and Abuse
MMR	maternal mortality ratio
NCMH	National Commission on Macro-Economics and Health
NFHS	National Family Health Survey
NGO	non government organization
OECD	Organization for Economic Co-operation and Development
OHCHR	Office of the High Commissioner for Human Rights
PAHO	Pan-American Health Organization
PDR	People's Democratic Republic
RHO	reproductive health organization
SAR	Special Administrative Region
STD/I	sexually transmitted disease/infection
SHG	self help group
TBA	traditional birth attendant
UNDP	United Nations Development Program
USAID	United States Agency for International Development
UNESCAP	United Nations Economic and Social Commission for Asia and Pacific
UNIFEM	United Nations Development Fund for Women
UNFPA	United Nations Population Fund
UN	United Nations

UNICEF
WHO
WHRAP

United Nations Children's Fund
World Health Organization
Women's Health Rights Advocacy Partnership

Reversing gender inequities in health and economy: Options for the future

IMPORTANT MESSAGES

Message 1

Gender inequities in health and health care exist in some form or other in almost all Asia-Pacific countries manifesting themselves in five different ways listed below:

- The biological health advantage of females in terms of resilience at birth is eroded through gender-based discrimination by adulthood in 78 per cent of Asia-Pacific countries, reflected in gender differentials in infant and under-five survival in 32 per cent of countries and a female-to-male healthy life expectancy ratio of below 1.06 in 71 per cent of countries.
- Specific health needs of women, men and sexual/gender minorities arising out of the intersection of sex and gender are grossly under-addressed in the majority of Asia-Pacific countries, reflected amongst other aspects in a maternal mortality ratio (MMR) of over 100 in two-thirds of Asia-Pacific countries. Diagnosis and treatment for sex-specific cancers for men and women (e.g. penile and cervical cancer), sex reassignment surgery for transgender groups, assisted reproductive technologies for lesbians and genital surgery for inter-sexed are rarely available in public health facilities.
- Human rights violations that discriminate against the health of women, girls, poor boys, and sexual/gender minorities are found in almost all Asia-Pacific countries. Such violations vary from country to country, but include male sex-selection before birth (in 29 per cent of countries on which data was available), female genital mutilation (in 17 per cent of countries on which data was available), greater malnutrition amongst girls than boys in the 0-5 age group (other than weight by height), early and forced marriage, adolescent pregnancy, lack of access to safe abortion (other than for sex selection), virginity testing and violence within the family and outside. Homosexuality amongst males is a crime in 55 per cent of Asia-Pacific countries and amongst females in 37 per cent of countries, and examples of violations of health rights of transgender, bisexual and inter-sexed people are common. Poor boys are vulnerable to being trafficked for sexual purposes, though to a lesser extent than girls in most countries.
- Although the economic ability of women and sexual/gender minorities to pay for health services is lower than that of men of similar economic status in Asia-Pacific countries, women pay for health services according to their economic capacities and not according to their need for services in at least 36.6 per cent of Asia-Pacific countries. This also discriminates against health access of poor men.
- Norms on dominant masculinities lead to higher prevalence of tuberculosis, cardiovascular diseases, HIV and intentional and unintentional injuries (including traffic accidents) amongst men than women. However, tuberculosis is underestimated amongst women, and the gender gap in the incidence of HIV is reducing across

generations. Deaths due to sexually transmitted infections (STIs) other than HIV are higher amongst females than males in Asia-Pacific.

Gender inequities in health, overall, more adversely affect the health of women and sexual/gender minorities than men of similar economic and social backgrounds. South and West Asian countries, with few exceptions, perform worse than East Asia and the Pacific with regard to gender inequities in health. In all countries women, men and sexual & gender minorities from economically, socially and politically marginalized groups face gender inequities in health to a greater extent. Industrialized countries perform better with regard to most health indicators in absolute terms, but not necessarily on gender and health equity issues. Son preference indicated in adverse sex ratios at birth persists in large parts of South Asia, and in China, the Republic of Korea, Viet Nam, Malaysia and Singapore.

Message 2

Gender inequities in the economy have a strong bearing on gender inequities in health in Asia-Pacific through six pathways listed below.

- The gender division of labor results in greater workloads for women and girls than for men and boys, and leads to differences in occupational health risks in all Asia-Pacific countries. The burden of caring for the sick falls disproportionately on women within the family (particularly in poor families).
- Intra-household biases against females in distribution of food, education expenditure and health-care expenditure leads to greater malnutrition (weight and height by age) and health risks for women and girls and lesser access to health care in about half of the Asia-Pacific countries on which data was available. However, weight by height malnutrition is higher amongst boys in a few countries, as is access to secondary and tertiary education in some.
- Gender inequities in earned income (in all Asia-Pacific countries), control over their own income, and ownership of land and assets imply that women have less ability to spend on their health, in particular when faced with catastrophic illness.
- Low and unequal presence of women and sexual/gender minorities in the formal sector implies that they have less access to health insurance/security than men and less access to means to pay for health-care services.
- Women's, men's and gender/sexual minorities' sex-specific health needs are rarely taken into account in the work place (other than maternal health within the institution of marriage).
- There are direct violations of the right to health and sexual rights and reproductive rights against women, against sexual/gender minorities and against men with stigmatized illnesses in the work place

Again, South and West Asia and developing countries perform worst on most gender and economic equity indicators, with the exception of Japan where inequities in the economic field fall near the developing country average.

Message 3

Gender inequities in health lead to gender inequities in the economy in Asia-Pacific through six pathways identified below.

- The health morbidities and stigma from gender/sexual based violence lead to job loss for women who were previously working, or loss of the ability to go out to work.
- Poor health (South Asia) and a lack of reproductive and sexual rights of women (all sub-regions) lower their ability to move up the economic ladder.
- Poor access to controversial services (e.g. legal abortion other than for sex selection) and low-priority sexual and reproductive health services (e.g. cervical cancer, penile cancer, sex reassignment surgery) in public health facilities leads to loss of income for women, men and sexual/gender minorities.
- Men, women and sexual/gender minorities with stigmatized illness are vulnerable to loss of employment and are denied promotion and training.
- Often, widows whose husbands die of AIDS lose access to the land and house owned by the late husband, especially when they test positive for HIV.
- The high expenditure of men on tobacco, alcohol and substance use in poor households in several countries (linked partly to inability to fulfill an expected bread-winning role) leads to a lower contribution of men toward household needs, and less ability of women to use part of their income to improve their enterprises.

Message 4

Deep-rooted causes of gender inequities in health and the economy in Asia-Pacific can be traced to three features of Asia-Pacific culture, social mobilization and governance.

- Unequal distribution of power between women and men and between sexual/gender minorities and heterosexual men and women in societal institutions, namely households, communities, markets and the state. This goes hand in hand with patrilineal inheritance systems, patrilocal residence systems and the practice of dowry in some countries.
- Unequal voice and agency of women and sexual/gender minorities and that of heterosexual men who wish to challenge the dominant construction of gender identities from community to national levels.
- Weak accountability of power holders in institutions of society listed above to address gender inequities in health and economy.

Patrilineal inheritance and patrilocal residence systems are prominent in South and West Asian countries, and used to exist in China, Viet Nam, and the Republic of Korea. Issues of unequal voice, power and weak accountability, gender inequity in health and gender inequity in the economy reinforce each other through vicious cycles.

Message 5

Good practices exist for breaking the vicious cycle -- through promoting gender equity in health, gender equity in the economy, and through strengthening power, voice and accountability.

These practices can be classified into the ‘development’ and ‘rights-based approaches’ both of which are important.

- *The development approach*, wherein action is more by government, donors and development NGOs: Examples of good practices under this approach include expanding government health expenditure as a percentage of total government expenditure in Nauru, expanding public health expenditure as a percentage of total health expenditure in Afghanistan, promoting universal social health insurance in Thailand covering women’s sexual and reproductive health needs, putting in place maternity insurance laws for women in enterprises in China, adding gender and health components to economic programmes targeted at women in Bangladesh, adding gender and livelihoods components to health programmes targeted at women in Lao People’s Democratic Republic, expanding girls’ access to secondary education in Bangladesh, sensitizing men on gender-based violence and on their own health needs in Fiji, sensitizing religious leaders in Cambodia on the reproductive health needs of women, men and young people and working with men as partners and parents to promote gender equity in health.
- *The rights-based approach*, wherein action is more often taken by civil social actors and aims at expanding voice and agency of the marginalized to demand accountability of power holders on gender equity in health and the economy. Examples of good practices within the second approach include advocacy by groups working around rights of sexual/gender minorities in Japan to stop victimization of transgender people in the work place, by women’s rights groups in Pakistan to remove rape from the ambit of *sharia* laws, advocacy by women’s rights groups to ban the practice of giving birth in cowsheds in parts of Nepal, pressure groups of rural women claiming gender specific health entitlements in India and Bangladesh, advocacy by groups working with sexual/gender minorities in Nepal to legalize homosexuality and same sex marriage, and media campaigns by men who believe in alternative masculinities in Philippines against dominant construction of masculinity and violence.

While these efforts are laudable there are more examples of citizens/others holding the government to account to promote gender equity in health and economy, than of holding leaders of community, market organizations and household heads to account. Strategies to make government provide controversial services (e.g. abortion other than for sex selection, enforcing land rights) or expensive health or economic services (e.g. breast or penile cancer treatment or universal unemployment insurance) have been less successful, than the provision of maternal health services or micro-credit to women. Accountability for the sex-specific health needs of sexual/gender minorities and their voice in public spaces is still minimal. National legislation on the right to participation in public policy formulation and oversight, right to health, right to food and livelihood security, and right to gender equity is not in place in many countries, and political equity is still a far cry.

Message 6

It is important to strengthen the accountability of government, donors, markets, communities and heads of households in Asia-Pacific to gender equity in health and the economy through policy/legal changes from above and pressure from below through the following strategies.

Rights-based approach

- Making international human rights instruments work for gender equity in health and the economy in the region through pressing governments that have not done so to ratify International Covenant on Economic and Socio Cultural Rights (41 per cent) and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1 per cent) and CEDAW optional protocol (71 per cent) and ICESCR optional protocol (yet to be opened for ratification), and pressing for Asia-Pacific Human Rights Court.
- Encouraging national governments to pass legislation on the right to participation, right to health, right to gender equity and right to livelihoods and property, and to bring their national legislation and policies into line with ICESCR and CEDAW. Promoting general accountability legislation such as public interest litigation and the right to participation to monitor implementation.
- Strengthening the powers and capacities of national women's commissions to address gender inequities disadvantaging women and girls in health and the economy, and that of national human rights commissions to take up health and economic violations against marginalized men and sexual/gender minorities.
- Supporting programs to strengthen voice and informed agency of women, sexual/gender minorities and men who want to challenge dominant masculinities at all levels: local, district, provincial, national, sub-regional and regional levels; in particular with regard to norms that support son preference, homophobia, male inheritance, patrilocality, dowry, and male decision making.
- Movement by government and donors beyond cost-effectiveness to a rights-based perspective on health priority setting so that the sexual and gender-specific health needs of women, sexual and gender minorities and men are addressed, including access to safe abortion other than for sex selection, access to services for the health consequences of gender-based violence, diagnosis and treatment for reproductive cancer and infertility amongst women and men, sex reassignment surgery for transgender people, assisted reproductive technologies for lesbians, treatment for prostate/penile/testicular/anal cancers of men, de-addiction services for those with substance use problems, and public health messages on masculinities and traffic accidents, tobacco use, substance use and violence.

Development approach

- Increase government allocations to health (including sexual and reproductive health) and increase public expenditure as a proportion of total health expenditure. Bi-lateral donors for their part need to fulfill their commitments to health made at International

Conference on Population and Development (ICPD) held in 1994 and the Millennium Summit.

- Improve economic, social and health security of those in the informal sector through employment guarantee schemes with equal wages, unemployment insurance, access to small and medium-scale credit, safe markets with sex/gender segregated toilets, crèches for workers, health and accident insurance for workers and pension schemes.
- Integrate gender and health with economic interventions targeted at women, sexual/gender minorities and poor men, and integrate gender and economic empowerment into health interventions targeted at women, sexual/gender minorities and poor men.
- Regulate private health and economic sectors so that they comply with national legislation on gender, health and economic equity.
- Engender public health and administrative systems through engendering policies, budgets, research, education and training, and strengthen the position of women, marginalized men and sexual/gender minorities within relevant departments.
- Improve sex-disaggregated data at regional/national levels on gender and health economic issues on which as yet no comparable United Nations (UN) data is available, such as women's ownership of land, reported incidence of domestic violence, access to screening for sex-specific cancers in men, legal status of homosexuality, legal access to abortion other than for sex selection etc.

Political and legal equality of women, marginalized men and sexual gender/minorities is essential for promoting gender equity in health and the economy.

1. INTRODUCTION

1.1 Background

Gender inequities in health disadvantaging Asia-Pacific women and girls persist throughout their life cycle, violating their right to the highest standard of health as enshrined in the General Comments to the ICESCR 2000 as well as their sexual and reproductive rights (UN 2000; WHO 2000a, , 2005a, 2006a). Gross violations of the health rights of women and girls in Asia-Pacific does not mean that the health of all men and boys is favorable in all countries or in all health realms. The World Health Organization (WHO) states that the lower life expectancy of males when compared to females worldwide and in Asia-Pacific may be attributed not just to the female biological advantage at birth, but also to higher rates of traffic accidents, consumption of tobacco, substance use, and risky behavior amongst men and boys; all of which are related to the dominant construction of masculinities (WHO 2002 2003a). The violation of rights to health and of the sexual and reproductive rights of sexual and gender minorities is another concern globally, and in the Asia-Pacific region.

The links between gender inequities in health and gender inequities in the economy have not been adequately explored in development research in Asia-Pacific, other than the relationship between gender, work and occupational health and gender, poverty, and health (with a focus on women and men). Whether issues such as unequal ownership of assets, unequal access to markets and incomes, unequal intra-household distribution of food, health and education, and unequal presence of women in economic leadership have a bearing on women's health has been little explored. Equally, the influence of women's morbidities and health rights violations on economic equity has been inadequately analyzed. Gender inequities in health and the economy affecting men and sexual/gender minorities have received less attention in research than those affecting women. The wider influence of lack or enjoyment of power, accountability and voice on gender inequity/equity in health and economy is another area where greater light is required.

1.2 Objectives

This paper seeks to bridge these gaps in the literature by examining the links, if any, between gender, health inequities and economic inequities in the Asia-Pacific region, documenting good practices in promoting gender equity in these two spheres through addressing the links, and suggesting policy measures to promote gender equity in health and economic status in the future. The focus of this paper is not just on gender, women's health and women's economic status, but also that of men and of gender/sexual minorities. The broader purpose of this paper is to contribute to the drafting of United Nations Development Programs (UNDP) Asia-Pacific Human Development Report (HDR) 2009 which focuses on Gender. The two sub-themes of the HDR are economic equity and politico-legal equity, with gender-based violence, culture and gender identities (including masculinities and gender minorities) as cross-cutting issues. The overarching framework of the HDR is the centrality of power and voice of women, marginalized men and gender/sexual minorities.

In keeping with this broader purpose, the specific objectives of this paper are the following:

- To capture major gender inequities in health in the Asia-Pacific region that have a bearing on the lives of women, men and gender/sexual minorities,

- To examine the linkages between gender inequities in health and in the economy in the Asia-Pacific region.
- To analyze how unequal distribution of power in society, inadequate voice (of marginalized persons) and weak accountability of power holders to women, marginalized men and gender/sexual minorities have perpetuated gender inequities in health and the economy.
- To document good practices in promoting gender equity in health and the economy and the links between them, and in challenging unequal power and voice and weak accountability.
- To frame important policy messages to foster gender equity in health and the economy through addressing the links, as well as the underlying causes.

Though the paper sought to examine the links between gender equity in health and economy, there was little on this topic, there was more material on the links between gender equity in economy and health.

1.3 Structure

The paper is structured as follows. The second section of this paper defines terms and concepts used in the paper and outlines the framework adopted to examine gender inequities in health and the economy (based on a review of literature). It also explains the indicators used in the paper, sources of data, and classification of sub-regions used for analyzing data. The third section provides an overview of the population, poverty and human development profile of the region, and the possible bearing of this profile on gender inequities in health in Asia-Pacific. The fourth and main section begins by providing an analysis of gender and health inequities in the region, using both statistical evidence and findings from qualitative research. It then examines evidence of the impact of gender and economic inequity on gender and health inequity and the evidence of the impact of gender and health inequity on economic inequity. The fifth section analyses the underlying unequal distribution of power and voice in society disadvantaging women, marginalized men and sexual/gender minorities which underpin gender inequities in the region. It also examines the strengths and weaknesses of processes of accountability of power holders in society – in state, markets, communities and households-- for gender equity in health and the economy. Comparative data on Sub-Saharan Africa is provided in Sections 3-5 where available in aggregated form. The sixth section summarizes good practices in reducing gender inequities in health, economy and power/voice through breaking unfavorable inter-linkages. The seventh section draws out policy implications that flow from the review of literature and the data for promoting gender inequity in health and the economy.

2. METHODOLOGY: DEFINITIONS, FRAMEWORK AND INDICATORS

2.1 Definitions

Concepts and terms such as health, right to health, economy, gender equity, gender equity in health, gender equity in the economy, gender analysis and a rights-based approach to development are outlined in this section.

Health

The constitution of WHO defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO n.d). The General Comment to the ICESCR on the Right to Health, 2000 (see Box 1) calls for the right of all persons to enjoy the highest attainable standard of health conducive to living a life in dignity (UN 2000).

Box 1. The Right to Health

The Right to Health includes:

- The right to maternal, child and reproductive health.
- The right to healthy, natural and safe workplace environments.
- The right to prevention, treatment and control of diseases.
- The right to health facilities, goods and services.
- The right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, the right to be free from torture, non-consensual medical treatment and experimentation.

The services have to be available, accessible, acceptable, and of appropriate quality. The following special topics are also to be kept in mind by national governments in health service provision: principles of non-discrimination and equal treatment, gender perspective, women's right to health, children's and adolescents' right to health, and right to health of older people, people with disabilities and indigenous people.

Source: United Nations 2000.

This paper examines whether the rights to health of women, men and sexual/gender minorities in Asia-Pacific are respected, protected and fulfilled.

Economy

The “free dictionary” defines the term economy as a system by which the production, distribution, and consumption of goods and services is organized in a country or community¹. This paper extends this definition to include how production, distribution and consumption of goods and services are organized in the country or community, as well as the household. It also examines how equitably these goods and services, as well as responsibilities, are distributed.

Gender equity

The concept of gender equity in this paper denotes the equivalence in life outcomes for women, men and, sexual/gender minorities; recognizes their different needs and interests; and requires redistribution of power and resources in favor of women, marginalized men and sexual/gender minorities. Gender equity is hence concerned with ‘justice and fairness’, and not ‘sameness’ which is implicit in the concept of gender equality (adapted from Reeves and Baden 2000). The concern of this paper is more with equity than equality.

Gender equity in health

Gender equity in health implies the absence of injustice in health outcomes, in meeting sex/gender differentiated health needs, and in fulfillment of health rights of men, women and gender minorities (Sen et al. 2007). Gender equity in health implies that the following five principles are upheld.

- Where biological sex places one sex at a health advantage, this should be reflected in better health outcomes for that sex.
- Where biological sex differences interact with social determinants to define different health needs for women, men and sexual/gender minorities the principle of gender equity would imply that these different needs are addressed adequately.
- Where no plausible biological reason exists for unjust health outcomes (e.g. early marriage of girls), social discrimination or violation of rights should be considered the prime reason and addressed accordingly.
- Where no plausible biological reason exists for different health outcomes (e.g. greater incidence of traffic accidents amongst men), social norms should be considered the prime reason and changed accordingly.
- Where economic ability to pay for health services varies among women, men and sexual/gender minorities and different economic groups amongst them, they should contribute to health financing according to their economic capacities and not according to their need for services. (Sen et al 2007; PAHO n.d.)

An important question posed by this paper is: how gender equitable is health services and outcomes in the region.

Gender equity in the economic sphere

Adapting from Murthy RK and Oxfam Great Britain (2007) gender equity in the economic sphere means:

- Equity in access to, ownership of and control overⁱⁱ family and community resources and assets by women, men and sexual/gender minorities.
- Equitable participation of women and men in reproductive work; and women's ability to control their own labour within the household.
- Equity in markets, in terms of participation rates, allocation of roles and tasks, the terms and conditions of work (including wages), earnings, access to training and promotion opportunities, ability to rise to leadership positions.
- Biological needs of women, men and sexual/gender minorities are taken into account by policy makers and employers (for example, leave for sex-specific health needs) as well as their social needs (for example for flexible working hours).

This paper examines how far gender equity in these economic aspects has been achieved in the region and has a bearing on gender equity in health.

Gender analysis

Gender analysis refers to the variety of tools used to understand the relationships between men and women, their activities and constraints, their access to and control over resources and power and their specific needs and interests. Gender analysis recognizes that gender and its relationship with race, ethnicity, caste, class, age, sexual/gender orientation, disability, and/or other social determinants of status is important to understanding the inequities that are seen in society between heterosexual men and heterosexual women, and between sexual/gender minorities and heterosexual men and women (adapted from CIDA 1999). Gender analysis is used throughout this paper to unravel underlying reasons that sustain gender inequity in health and the economy in Asia-Pacific.

Rights-based approach to development

A rights-based approach to development is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. The human rights based approach identifies ‘rights holders’ and their entitlements and duty bearers and their obligations, and works towards strengthening the capacity of rights holders to make claims and duty bearers to fulfill their obligations (United Nations 2006).

This paper considers gender and health/economic equity to be closely linked to realizing rights enshrined in the International Covenant on Economic, Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination against Women, and the International Covenant on Civil and Political Rights.

2.2 Framework to examine gender inequities in health and economy

Antecedents to the framework

A review of literature on health equity by Gwatkin (2007) suggests that the attention to health inequities began in the 1990s. Whitehead (1992) observed that differences in health care access and outcomes are not only unnecessary and avoidable, but in fact unfair and unjust. In the 1990s, Evans and Brown argued through a series of articles that the place of residence, race, occupation, sex, religion, education, socio-economic status and social capital are important determinants of health inequity (Evans and Brown 2002). Marmot in 2006 observed that poor health amongst disadvantaged groups results not just from lack of material resources, but also from psychological factors such as lack of empowerment (Marmot 2006).

Analysis of gender inequities in health and the inter-relations between gender norms, inequity and health was not the main attention of most of these early researchers on health inequity (Gwatkin 2007). A major landmark in summarizing and analyzing international evidence on gender inequities in health was the edited book *Engendering International Health: The Challenge of Equity*, by Sen, et al. (2002) which brought together articles that forcefully argued that to fully comprehend the distribution of health and illness, one needs to include not only sex, but also gender in one's analysis. One chapter of this book explored the link between women's work and women's health (Ostlin 2002). Ostlin noted that unlike in the

industrialized countries where there is evidence of a positive relation between women's economic participation and women's health (in spite of discrimination at the work place) the evidence from developing countries is more ambiguous as women, like men, commonly work in the informal sector, are engaged in hazardous jobs and work under insecure terms and conditions. Men and women, especially in developing countries, are exposed to different health risks given the gender-based division of labor in the work place, and poor adherence to safety standards. In addition, women in developing countries earn lower wages than men, have fewer chances for training and promotion, have to make do with tools suited to the height and weight of men, have to combine their paid work with unpaid and often unsafe work at home, and have to work for extremely long hours. The 2006 WHO publication, 'Gender Equality, Work and Health: A review of the evidence' further explored the link between these three aspects (Messing and Ostlin 2006).

Unlike much of the literature on gender, work and health, which tend to take a unidirectional linear view that gender inequities in the work place have a bearing on gender inequities in health, the literature on gender, poverty and health point to the vicious circle linking gender, poverty and ill health. As early as 1998, Oxaal and Cook observed that poverty leads to women's overwork, hazardous work and poor nutrition (given intra-household gender inequalities). Certain conditions of ill health (including malnutrition) amongst women lead in turn to women's economic exclusion and subsequent ill health, pointing to the cycle of ill health and poverty (Oxaal and Cook 1998).

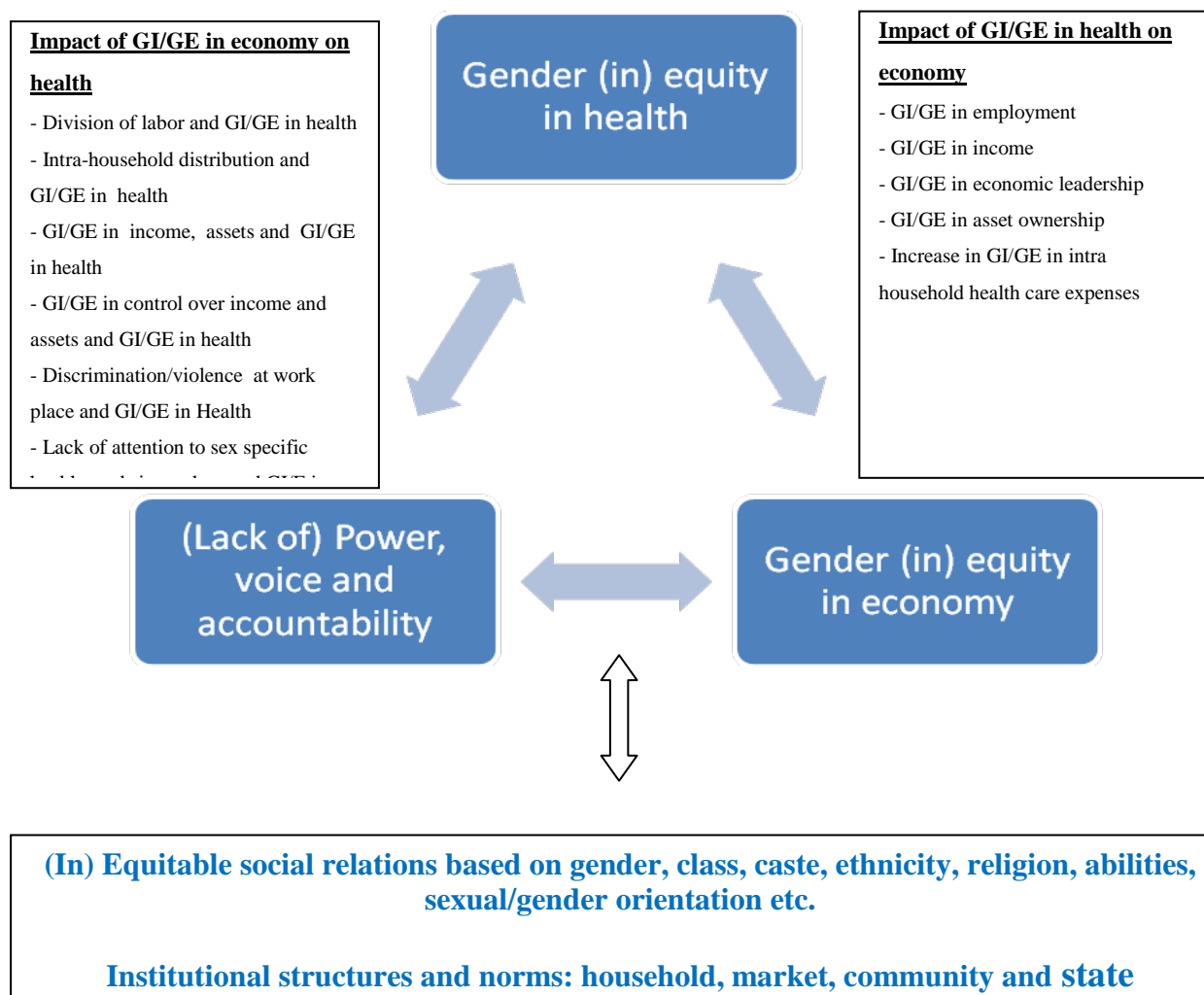
The WHO series on gender, poverty and health has explored not only the vicious linkages, but virtuous cycles that are possible when one addresses the underlying causes of poverty and ill health through a gender lens (WHO 2005a, and 2006a). The WHO Pacific report 'Integrating Poverty and Gender into Health Programs: Foundation Module on Poverty' points out first, that higher incomes lead to better health and better health improves income and welfare, and second that higher incomes in women's hands lead to better health care for themselves and their children. The module argues that greater income in women's hands leads to better nutrition and greater access to ante-natal care (ANC), and improved maternal health improves their ability to earn an income. Citing evidence from China, Indonesia and Sri Lanka the module also observes that an increase in iron supplementation for anemic workers increased their work productivity, incomes and leisure time. This in turn could lead to better health (WHO 2006a). While not citing concrete evidence, the module argues that assets in women's names, absence of intra-household inequalities in the distribution of food, nutrition, and education, and reductions of women's work load could all lead to reducing gender inequities in women's health that disadvantage women.

What then are the reasons for gender inequities in health, work and poverty? Sen et al. (2007) contend that gender-discriminatory values, norms, practices and behaviors, differential exposure and vulnerability to diseases, disabilities and injuries, biases in health systems and biases in health research are principle reasons for gender inequities in health outcomes. They note that these discriminatory values in turn are shaped by gender and social relations of caste, class, race, ethnicity, sexual/gender orientation etc. One could argue that the unequal distribution of power in societal institutions -- states, markets, households, communities -- shapes the marginal location of women, marginalized men (and different groups amongst them) and sexual/gender minorities in these social relations. The unequal distribution of power is both caused by, and manifested in, the weak accountability of power holders and inadequate mobilization of women, marginalized men and sexual/gender minorities to voice their needs and interests.

Framework on gender (in) equity in health and the economy

This paper builds upon the frameworks pertaining to three issues: i) gender inequities in health, ii) gender, health and work and iii) gender, poverty and health to postulate a framework of ‘vicious spirals’ and ‘virtuous spirals’ to explore the links between gender (in)equity in health, the economy and issues of power, accountability and voice.

**Figure 1. Vicious and virtuous spirals:
Framework on gender (in) equities in health, the economy and power and voice**



Note: GI: Gender Inequity, GE: Gender Equity

Constructed on basis of Blumberg 2005, Food and Agriculture Organization 2004, Marmot 2006, Murthy R.K 2007, Wardlow, 2002, and WHO 2006a.

To illustrate the framework, ill health and injury combined with lack of access to health care and inadequate representation in trade unions can lead to loss of jobs, inability to work at the previous level, lower earnings, loss of housing and loss of property. The economic loss in turn can lead to poorer nutrition and ill health (WHO 2006a). This vicious circle is particularly marked in the case of women, sexual/gender minorities and men from marginalized groups. At the same time the picture is not entirely bleak. There are virtuous cycles as well. Based on an analysis of gender, economic and health/social indicators in 61

societiesⁱⁱⁱ and a review of the literature, Blumberg (2005) argued that increasing women's control over income and other economic resources through legislation, programs and strengthening pressure groups from below decreases domestic violence against women, enhances their decision-making power concerning their own marriage, divorce, sexuality, fertility and mobility, and leads to greater gender equity in the allocation of food and nutrition in the household. She observed that female education also has a similar effect. To support her claim on the links between economic and health indicators, studies in South Africa have shown the positive effects on women's health of combining micro credit with health programs, as well as the impact on women's health of promoting property rights (Sen et al. 2007). However the literature on virtuous cycles is much less prevalent than that on vicious cycles globally and in Asia-Pacific, pointing to the need to document positives linkages.

2.3 Indicators, databases and classification of countries

Indicators for analysis

A variety of indicators have been used here for examining gender [in]equities in health and the economy and issues of (lack of) power, voice and accountability. Some indicators are female-to-male ratios, some apply more or only to females, males or sexual/gender minorities, and a few are general ones which have greater ramifications for marginalized groups. A total of 82 indicators, which are outlined in Table 1 have been used for analysis in this paper. Of these 82 indicators, inter-country data was available on 36, and not available on the others. Unfortunately, inter-country data are not published in the UN/World Bank databases on a variety of controversial health outcomes for women (e.g. abortion rates, incidence of violence against women), nor on access of men and sexual/gender minorities to health services specifically required by them (e.g. access to treatment for prostate cancer or sex-assignment surgery). This lack of data also applies to sex-specific health needs which are not seen as a public good, such as access to treatment for cervical cancer in public health facilities.

Table 1. List of indicators used for analysis in the report

Theme	Indicators across themes				
	Female-to-male comparisons	Female-specific indicators	Male-specific indicators	Sexual./gender -minority-specific indicator	General indicators
Gender [in]equities in health	<ul style="list-style-type: none"> - Sex ratio at birth - F/M ratio of infant mortality rate - F/M ratio of under-five mortality rate - <i>Gender differences in access to immunization.</i> - F/M ratio of healthy life expectancy at birth - F/M ratio of adult mortality rate - <i>Sex/gender differences in weight for height, weight for age, height for age; body mass index and</i> 	<ul style="list-style-type: none"> - Adolescent fertility rate - Incidence of early marriage amongst girls - ANC coverage (%) - Births attended by skilled health personnel (%) - Access to legal abortion on demand (other than for sex selection) - Maternal mortality ratio - Lifetime risk of 	<ul style="list-style-type: none"> - <i>Deaths amongst men due to prostate cancer (%)</i> - <i>Testicular cancers as a percentage of all cancers amongst men</i> - <i>Penile cancer as a percentage of all cancers amongst men</i> - <i>Sexual dysfunction</i> 	<ul style="list-style-type: none"> Legal status of homosexuality and same-sex marriage <i>Anal cancer amongst gays and bi-sexual men</i> <i>Breast cancer amongst lesbians</i> <i>Access in public facilities to genital surgery</i> 	<ul style="list-style-type: none"> General government expenditure on health as percentage of total expenditure on health (%) Out-of-pocket expenditure as % of private expenditure on health Social security expenditure as % of general

	<i>anemia</i> - Male methods of modern contraception as % of total modern contraceptive methods - F/M ratio of prevalence of current tobacco use (adults and adolescents) - F/M ratio of HIV prevalence rate - DALYs by cause, sex, age and region	maternal death - Low birth weight newborns (%) (reflecting maternal health) - Incidence of physical and sexual violence against women - Customary practices harmful to health of women and girls - Women who have had PAP smear (%) - Women who have had mammography (%)	amongst males - Access in public facilities to treatment for male-specific cancers	for inter-sexed Access in public facilities to sex reassignment surgery Access from public facilities to assisted reproductive technologies for lesbians	government expenditure on health
Gender [in]equities in economy that have a bearing on health	- Female economic activity rate as % of male rate - Employment in informal sector as % of non-agricultural employment - Employment by economic activity, % (agriculture, industry, services) - Gender division of labor - Total work in market and non- market activities (hours and minutes per day) - Ratio of estimated female-to-male earned income - Gender differences in access to food and health - Ratio of female-to-male gross primary, secondary and tertiary enrolment - Gender differences in control over income - Gender differences in land ownership	- Length of paid maternity leave - Maternity leave benefits - Access of unmarried women to maternal leave - Access to maternity leave for women who adopt - Access of women to leave for abortion - Accommodation of less work travel needs during menstruation - Access to female toilets - Sexual harassment of women in work place - Access to comprehensive insurance at work place for health needs of women	- Access to comprehensive insurance for health needs specific to men	- Non-discrimination in work place based on sexual/gender orientation - Access to leave for genital surgery, sex-assignment surgery and availing of assisted reproductive facilities - Access to toilets for transgender and inter-sexed people - Access to comprehensive health insurance for health needs of sexual/gender minorities	
Gender inequities in health that have a bearing on the economy		- Violence against women and loss of job/lesser ability to work due to following: - Poor access to sex-specific health services and lesser incomes of women	Lack of access to services required only/more by males and loss of income	Poor access to controversial services required specifically by sexual/gender minorities and loss of income	Excess spending (mainly by men) on alcohol, tobacco use, gambling and lesser money for family to invest in enterprises of women and men

		<i>- Health morbidities affecting women more and lesser ability to move up the economic ladder</i> <i>- Lack of reproductive rights, child care and lesser ability to move up the economic ladder</i>			
Power, accountability and voice	<i>- % of women in decision making in community leadership</i> <i>- Seats in parliament held by women (% of total)</i> <i>- Female legislators, senior officers and managers (% of total)</i> <i>- % of women in local self governance</i> <i>- % of women in trade unions</i>	<i>- Women's role in health decision making</i> <i>- Women's own attitudes on gender norms</i> <i>- Ratification of CEDAW and optional protocol</i> <i>- Presence and powers of national commission of women</i> <i>- Legislation on right to gender equality</i> <i>- Legislation on domestic violence and violence against women at work place</i>			<i>- Ratification status of ICESCR and ICCPR</i> <i>- Law on Right to participation</i> <i>- Law on right to health</i> <i>- Presence and powers of human rights commission</i> <i>- Policies and legislation to further accountability of private health sector</i> <i>- Policies and legislation to regulate traditional leaders</i> <i>- Labor laws for those in informal sector</i>

Note: Indicators for which no quantitative data was available are indicated in *italics*, and those for which quantitative data was available are indicated in normal font.

Databases

Inter-country data for 36 indicators below (the majority of which are defined in Table 2) are used for analyzing gender inequities in health, the economy and issues of power, accountability and voice in Asia-Pacific has been drawn from several databases, listed below.

- World Health Statistics 2008 (WHO 2008a).
- Human Development Report 2007/2008 (UNDP 2007).
- Progress of the World's Women 2008/2009 (UNIFEM 2008).
- Global Gender Gap Report 2008 (World Economic Forum 2008).
- Gender, Institutions and Development Database 2009 (OECD 2009).
- Global Burden of Disease and Risk Factors 2006 (Lopez et al 2006).
- Report on Ending Violence Against Women, 2003 (UNIFEM 2003).
- LGBTI rights by country or territory database (Wikipedia 2008).

- Abortion Laws by Country or Territory 2007 database (Pregnant Pause n.d).
- State of World Population (UNFPA 2007).
- The State of the World's Children, 2006 (UNICEF 2006a).
- World Development Indicators database, 2009 (World Bank n.d).
- OHCHR database on status of ratification of international treaties (OHCH, n.d).

The databases use a variety of classifications of countries/areas falling within the 'Asia-Pacific' region, and sub-regions within Asia-Pacific (South Asia, East Asia and Pacific, West Asia), and in this paper the UNDP Regional office's system has been adopted (however information on Tokelau and Macao, China (SAR) was not available from the databases). This classification is given in Table 2. The classification of 42 countries/areas in the HDR 2007/2008 into industrialized and developing has also been adopted in this report (UNDP 2007). The purpose is to examine whether gender inequities in health and economy, as well as access to power in society, vary among sub-regions within Asia-Pacific and among developing and industrialized high-income countries/territories (UNDP 2007). Wherever consolidated data is available a comparison is made between gender inequity in health, economy and access to power in society in Asia-Pacific and Sub-Saharan Africa.

Table 2. Classification of Asia-Pacific countries/areas adopted in this report

Classification of Asia-Pacific countries/area				
	Eastern Asia	Pacific	South and West Asia	Total number of countries/areas
Developed	Japan	Australia New Zealand	-	3
Developing	Cambodia China Hong Kong, China (SAR) Korea, Democratic People's Republic of Lao People's Democratic Republic Mongolia Viet Nam Brunei Darussalam Indonesia Malaysia Myanmar Philippines Republic of Korea Singapore Thailand Timor-Leste	Fiji Kiribati Marshall Islands Federated States of Micronesia Nauru Palau Papua New Guinea Samoa Solomon Islands Tonga Tuvalu Vanuatu	Afghanistan Bangladesh Bhutan Iran, Islamic Republic of Nepal Maldives Pakistan Sri Lanka	37
Unclassified		Cook Islands Niue		2
Total	17	16	9	42

Source: Developed by the author based on classification system adopted in UNDP 2007.

3. POPULATION, POVERTY AND HUMAN DEVELOPMENT PROFILE OF ASIA-PACIFIC

An overview of the population, poverty and human development profile of the Asia-Pacific countries/areas (from now on referred to as countries) is provided to set the context for the analysis of gender inequities in health and linkages with gender inequities in the economy, which follows in the next section.

- *Population:* The total population of 40 countries^{iv} of the Asia-Pacific region on which data was available was 3,700 million in 2005, which is significantly higher than the population of Sub-Saharan Africa at 722.7 million (UNDP 2007). The majority of the population of Asia-Pacific live in East, South and West Asia (computed from UNDP 2007). The average population size of Pacific countries (2.3 million) is much smaller than that of East Asia (122.4) and South and West Asian countries (176.4 million). The average population of developing East Asian countries is more than that of industrialized countries, but in the Pacific the trend was the reverse. China and India together account for approximately two-thirds of the regional population.
- *Spatial distribution of population:* Data available on 32 countries^v of the region from the HDR 2007/2008 suggests that 44 per cent of the population in these countries lived in urban areas in 2005. The comparative figure for Sub-Saharan Africa was 34.9 per cent. The proportion of urban population was higher than the Asia-Pacific average in the case of East Asian countries (53.2 per cent) and lower than the average in the case of South and West Asian (28.4 per cent) and Pacific countries (40.7 per cent) (computed from UNDP 2007). The proportion of urban population was higher than the average for Asia-Pacific in the industrialized countries (80.1 per cent) of the region and lower than the average in the case of developing countries (40.1 per cent) (computed from UNDP 2007).
- *Dependent population:* Data on the dependent population can be computed for 32 countries^{vi} by adding the figures on the proportion of population 15 years and below, and the proportion of the population 65 years and above from the figures in HDR 2007/2008. The data suggests that a high 36.6 per cent of the population is dependent on those who are 16-64 years as of 2005. However, the proportion of the dependent population in Asia-Pacific is lower than that of Sub-Saharan Africa, where dependents (mainly children) constitute 46.7 per cent. The proportion of the dependent population is slightly higher in Pacific countries (40.3 per cent) than the Asia-Pacific average, the same as the regional average in the case of South and West Asian countries (37.5 per cent) and slightly lower in the case of East Asian countries (34.4 per cent) on which data was available (computed from UNDP, 2007). The dependent population was slightly lower than the regional average in the case of industrialized Asia-Pacific countries (33.3 per cent) and more or less the same in the case of developing countries of the region (37 per cent) (Computed from UNDP 2007).
- *Human Development index (HDI):* The average HDI value for the 32 Asia-Pacific countries^{vii} on which data was available from the HDR 2007/2008 was 0.730 as of 2005 (computed from UNDP, 2007). The comparative figure for Sub-Saharan African countries stood much lower at 0.493 for the same year. Only 9 of the 32 Asia-Pacific countries (36 per cent) were classified as high human development countries^{viii} with the rest being classified as medium human development countries. The East Asian and Pacific countries recorded slightly higher levels of human development (0.764 and 0.759

respectively) than the regional average, while South and West Asian countries recorded significantly lower levels of human development (0.634). The developing Asia-Pacific countries recorded lower levels of human development than the regional average (0.707), with the reverse being true in the case of industrialized countries (0.953) (computed from UNDP 2007).

- *Human poverty:* Data from HDR 2007/2008 on 24ix Asia-Pacific countries (all developing) suggests that in these countries an average of 24.1 per cent of population live in human poverty (2005) with the proportion being higher in the case of South and West Asian (29.1 per cent) and Pacific countries (27.1 per cent) and lower in the case of East Asian countries (19.7 per cent) (Computed from UNDP 2007). No consolidated data on the proportion of the population living in human poverty was available for Sub-Saharan Africa from the UNDP Human Development Report, 2007/2008.
- *Population in income poverty:* Data on income poverty from HDR 2007/2008 on 15 Asia-Pacific countries^x for the period 1990 to 2005 indicates that 16 per cent of the population lived below an income level of US\$1 per day and 48 per cent lived below US\$2 per day^{xi}. Data from the State of the World's Children, 2006, suggests that a high 45 per cent of the population lived below the income poverty line of US\$1 per day during the period 1993-2003 (UNICEF 2006a). The levels of income poverty were higher than the average for Asia-Pacific in the case of South and West Asian countries (24.5 per cent, and 59.2 per cent respectively), and lower in the case of East Asian countries (17.35 per cent and 45.2 per cent respectively). No data on income poverty was available for Pacific countries or industrialized countries (computed from UNDP 2007).
- *Population with access to improved drinking water:* Data from the World Health Statistics 2008 on 33 Asia-Pacific countries^{xii} suggests that 81.4 per cent of the population in these countries had access to improved drinking water as of 2006, which is much higher than the comparative figure for Sub-Saharan African countries wherein only 58 per cent of the population has access to improved drinking water as of 2007 (World Bank, n.d; WHO 2008a). The proportion of population with access to improved drinking water was slightly higher than the Asia-Pacific average in East Asian countries (83.8 per cent) and slightly lower in the case of South and West Asian countries (77 per cent), and more or less similar in the case of Pacific countries (81.8 per cent). The proportion with access to improved drinking water was significantly lower in rural (77.8 per cent) compared with urban areas (89.5 per cent), and in developing (79 per cent) compared with industrialized Asia-Pacific countries (100 per cent) (computed from WHO 2008a).
- *Population with access to improved sanitation:* Data from the World Health Statistics 2008 on 32 Asia-Pacific countries^{xiii} for the year 2006 suggests that only 63.5 per cent of the population in these countries had access to sanitation. However, access of the population to sanitation is better in Asia-Pacific than in Sub-Saharan Africa, which stood at 31 per cent in 2007 as per World Development Indicators database (World Bank, n.d). The proportion of the population with access to improved sanitation was slightly higher than the Asia-Pacific average in Pacific countries (71.5 per cent) and East Asian countries (66.6 per cent) and significantly lower in South and West Asian countries (47 per cent). The proportion with access to sanitation was significantly lower in rural (56.6 per cent) compared with urban areas (79.6 per cent), and in developing (58.3 per cent) compared with in industrialized Asia-Pacific countries (100 per cent) (computed from WHO 2008a).

Asia-Pacific Countries that score below the Asian average on most of the above indicators include: India, Nepal, Bangladesh, Bhutan, Pakistan, Cambodia, Lao People's Democratic Republic, Papua New Guinea and Timor-Leste. Though data was not available on most of the above indicators on Afghanistan it is likely that the country would be included in this list.

The implications of the population, poverty and human development profile of the region for gender inequities in health are many, and the important ones are discussed in Box 2

Box 2. Implications of the population, poverty and human development profile of Asia-Pacific for gender inequities in health

- Women in urban poor areas in developing Asia-Pacific are more likely to live in congested areas, and face violence more than their counterparts in rural areas.
- There is a substantial work burden of Asia-Pacific women in looking after a 36.6 per cent share of dependent population in addition to engaging in paid work
- Women's health is more sensitive to chemical pollution than men's due to sex differences in absorption, metabolism and excretion of fat-soluble chemicals.
- Rural women in developing Asia-Pacific countries spend substantial time fetching water, which may be unsafe, washing clothes and vessels; this leads to vulnerability to water-borne diseases such as schistosomiasis^{xiv}, malaria and worms. Schistosomiasis in turn is associated with risks of infertility, abortion, and vulnerability to HIV infection.
- Women in developing Asia-Pacific countries living without access to sanitation may face greater incidence of urinary tract infections, as well as being vulnerable to sexual violence.
- Poor women in the developing countries of Asia-Pacific wherein poverty indicators are worse may be compelled into prostitution to supplement their income and may be vulnerable to trafficking.
- Women in urban poor areas in developing Asia-Pacific are more likely to live in congested areas, and face violence more than their counterparts in rural areas.

Source: Adapted from Sen et al 2002, 2007; WHO 2000a 2006a.

4. GENDER INEQUITIES IN HEALTH AND ECONOMY

4.1 Gender inequities in health

As elaborated in the section on definitions, gender inequities in health could take five forms: erosion of the female biological advantage at birth, failure of public health facilities to meet sex/gender-specific health needs, violation of human rights which have a bearing on health, high-risk behavior of men due to the construction of masculinities and inequitable health financing systems. Examples in Asia-Pacific of gender inequities in health arising out of all these five factors are presented in this section. See Table 3 for a summary. The terms women and men when used in this report refer to heterosexual women and men, and the term sexual/gender minorities refers to lesbians, gays, bi-sexual, transgender and inter-sexual people.

Table 3. Summary of gender inequities in health in Asia-Pacific

Principles on gender equity in health	Illustration of violation of the principle in Asia-Pacific
<p>Principle 1: Where biological sex places one sex at an advantage this should be reflected in better health outcomes for that sex</p>	<p>Biological health advantage in terms of female advantage^{xv} at birth eroded progressively with age through discrimination and neglect in 78% of 41 Asia-Pacific countries on which data was available reflected in greater/same female IMR, under-five mortality rate, adult mortality rate and healthy life expectancy below the stipulated 1.06.</p>
<p>Principle 2: Where biological sex interacts with gender to create different health needs for women, men and sexual/gender minorities these needs should be addressed</p>	<p>Several of the Asia-Pacific countries have not met:</p> <ul style="list-style-type: none"> - Specific health needs of women such as access to full ante-natal care, institutional delivery, maternal nutrition, emergency obstetric care, cervical and breast cancer prevention/treatment and safe abortion needs (other than for sex selection). These factors in turn have led to high maternal mortality ratio in some countries. - Specific health needs of men such as prevention, screening and treatment for prostate cancer, testicular cancer, penile cancer and sexual dysfunction^{xvi}. - Universal access to contraception for heterosexual couples and adolescents. - Specific health needs of sexual/gender minorities such as access to sex-change operations for transgender people, genital surgery for inter-sexed people, assisted reproductive technologies for lesbians and anal cancer amongst gays.
<p>Principle 3: Where no plausible biological reason exists for unjust health outcomes, gender discrimination should be considered the main reason</p>	<p>Violations of principle 1, and:</p> <p>Gender discrimination in the region leads to violations of right to health and of sexual and reproductive rights of women and girls reflected in male-biased sex ratio at birth, greater female malnutrition (other than height for weight), practice of female genital mutilation in some countries, early marriage of girls, adolescent pregnancy, women bearing the burden of contraception, and physical and sexual violence against women and girls in and outside families in many countries</p> <p>Discrimination against sexual and gender minorities persists in the region, with 45% of countries having decriminalized homosexuality for men and 63% for women</p>
<p>Principle 4: Where no plausible biological reason exists for different health outcomes for men and women, gender norms (but not discrimination) should be considered the main reason</p>	<p>Higher rates of substance use and risky health behaviour lead to greater death rates due to tuberculosis, HIV (in Asia), traffic accidents and public violence amongst men, homosexual men and transgender (male to female) people than amongst women</p>

<p>Principle 5: Where economic ability to pay for health services varies across women, men and sexual/gender minorities (and different groups amongst them) they contribute to health financing according to their economic capacities and not according to their need for services.</p>	<p>Though economic ability of women and transgender/intersex people to pay for health services is lower, they pay for health services according to their economic capacities and not according to their need for services in at-least 36.6% of 41 Asia-Pacific countries on which data was available</p>
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4.1.1 Erosion of the female biological advantage at birth

The female biological advantage at birth is eroded progressively with age through discrimination and neglect in 78 per cent of Asia-Pacific countries.

Worldwide, infant, child and adult mortality rates for males are higher than that of females, and women outlive men. According to the Global Gender Gap Report 2008 the healthy life expectancy of women should be 1.06 times that of men (World Economic Forum 2008^{xvii}). The female XX chromosomes are supposed to enhance chances of females surviving the first year, the first five years, and even morbidities such as cancer (Micheli 1998; Fikree and Pasha 2004; Fuse and Crenshaw 2005). The biological advantage of females over males at birth does not apply to vulnerability to obesity, to diseases/conditions associated with low levels of hemoglobin, to osteoporosis after menopause and to contracting sexually transmitted infections from infected male partners (WHO 2000a, 2003b, 2006a). The biological advantage also does not apply to the added vulnerability of women during pregnancy; when exposure to diseases like malaria can be additionally dangerous.

In the Asia-Pacific region this biological advantage at birth is eroded due to discrimination and neglect in the majority of countries, and takes several forms discussed below. Consolidated comparative data is provided for Sub-Saharan Africa where available,

- *Female infant mortality rate higher than or equal to male infant mortality rate in 10 of 41 Asia-Pacific countries^{xix} on which data was available from World Health Statistics 2008 (WHO 2008a).* In China, Viet Nam, Palau, Tonga, Nauru, Tuvalu and India female infant mortality was higher than male infant mortality in 2006. In Federated States of Federated States of Micronesia, Japan and Nepal female and male infant mortality rates were equal in 2006, indicating that gender discrimination persists even in these two countries. In the 41 countries as a whole, however, female IMR on average (un-weighted) was lower than male IMR in 2006 (ratio of female-to-male IMR is 0.85). The ratio of female-to-male IMR is lower than the regional average in South and West Asian countries (0.83), but higher in East Asia at 0.87 and same in Pacific at 0.85. In developing Asia-Pacific countries the ratio of female-to-male IMR is slightly higher than the regional average 0.88, while in industrialized countries the ratio is lower than the regional average at 0.78.
- *Female under-five mortality rate is higher than or equal to male under-five mortality rates in 10 of 41^{xx} Asia-Pacific countries on which data was available as of 2006*

(WHO 2008a). These include China, Nauru, Palau, Solomon Islands, Tonga, Tuvalu and India. In Federated States of Micronesia, Republic of Korea and Singapore the female under-five mortality rate was the same as the male under-five mortality rate. In the 41 countries as a whole, however, the female under-five mortality rate was lower than male under-five mortality rate (ratio of female-to-male under-five mortality rate was 0.89) in the year 2006. It is notable that the ratio of the female-to-male under-five mortality rate is slightly higher than the ratio of female-to-male infant mortality rate pointing that the biological health advantage is reduce after the first year of life. The ratio of the female-to-male under-five mortality rate in South and West Asian countries is slightly higher than the 41-country average (at 0.92), and more or less the same in East Asian and Pacific countries (at 0.88). In developing Asia-Pacific countries the ratio of the female-to-male under-five mortality rate is slightly higher than the regional average of 0.92, while in industrialized countries the ratio is lower than the regional average at 0.81.

- *The ratio of female-to-male healthy life expectancy at birth is below 1.06 in 29 of 41^{xxi} Asia-Pacific countries on which data was available as of 2002 (WHO 2008a).* The twelve countries which were exceptions were Cambodia, Japan, Republic of Korea, Mongolia, Philippines, Thailand, Myanmar, Timor-Leste, Fiji, Kiribati, Nauru and Sri Lanka. That is, the biological health advantage at birth of females is increasingly lost as they grow older, likely due poorer, discrimination, discrimination and neglect. In the 41 countries as a whole the healthy life expectancy of females was the same as that of males (ratio of female-to-male healthy life expectancy at 1.04) as of 2002. The ratio of female-to-male healthy life expectancy is lower than the average in South and West Asian countries (1.01) and the Pacific (1.03), but higher in East Asian countries (1.05). That is, only East Asian average comes close to meeting the biological advantage standard of 1.06. The female-to-male healthy life expectancy ratio was higher in industrialized (1.06) than developing Asia-Pacific countries (1.03), with the difference being less marked in Pacific industrialized countries. The countries that recorded lower female-to-male healthy life expectancy as of 2002 were Maldives, Nepal, Pakistan, and Bangladesh, and similar healthy life expectancy at birth were India, Tonga, Tuvalu and Lao People's Democratic Republic.
- *Adult mortality rate for females is higher than that for males in 4 countries out of 41^{xxii} on which data was available (WHO 2008a).* These include Palau, Tonga, and Tuvalu in the Pacific and Bangladesh in South Asia. In no country of the region was the adult mortality rate the same for both sexes. In the 41 countries, the female adult mortality rate was lower than that of males as of 2006 (ratio of 0.73). The ratio of the female-to-male adult mortality rate was higher than this average in South and West Asia (0.78) and the Pacific (0.81), and lower in East Asia (0.64), showing that the female advantage is lower in the first two sub-regions. The ratio of the female-to-male adult mortality rate was lower in developing Asia-Pacific countries (0.76) and higher in industrialized Asia-Pacific countries (0.57).

In total, in 32 countries out of 41 there were sex differences in infant, under-five mortality or adult mortality, or the female-to-male healthy life expectancy ratio was below 1.06.

4.1.2 Specific health needs of women, men and sexual/gender minorities ignored

Specific Health needs of women, men and sexual/gender minorities arising out of the intersection of biology and gender are grossly under-addressed in more than 75 per cent of Asia-Pacific countries.

Sex and gender intersect to create specific health needs for women, men and sexual/gender minorities. This sub-section examines whether or not these health needs are met. While regional and sub-regional performance is summarized below for industrialized and developing countries.

Specific health needs of women^{xxiii}

- *ANC coverage was less than 80 percent^{xxiv} in 9 of 12 Asia-Pacific countries^{xxv} (75 per cent) for which data was available for the years 2000-2006, namely Cambodia, Viet Nam, Myanmar, Philippines, Thailand, Timor-Leste, Bangladesh, India and Nepal (WHO 2008a). The three countries amongst the 12 wherein ANC coverage was 80 per cent or more were Democratic People's Republic of Korea, Indonesia and Maldives. In the 12 countries (all developing) average ANC coverage was only 54.9 per cent showing a gross neglect of a health care need which affects only females (and on average approximately 3 times in their lives assuming a total fertility rate of 2.9 which is the regional average for 2000-2005). ANC coverage in South and West Asian countries on which data was available was lower than the average in the 12 countries (at 46.8 per cent), while the reverse was true in the case of East Asian countries on which data was available (59 per cent). No data on ANC coverage was available in Pacific countries or in industrialized countries. Amongst the 12 countries, ANC coverage varied from 16 per cent in Bangladesh to 95 per cent in Democratic People's Republic of Korea. Apart from the fact that ANC coverage is limited, an issue is that ANC services do not include preventive messages and measures to reduce susceptibility to conditions such as Malaria (Sen et al. 2007). ANC coverage seems to be better in Sub-Saharan Africa than Asia-Pacific, with the figure standing at 72 per cent in 2007 (World Bank n.d.), but the total fertility rate was higher in Sub-Saharan Africa at 5.5 (UNDP 1997), a further factor putting women at greater risk.*
- *Fewer than 80 per cent of births^{xxvi} were attended by skilled health personnel in 14 out of 41 (34 per cent) Asia-Pacific countries for which data was available for 2000-2006, namely Cambodia, Lao People's Democratic Republic, Indonesia, Myanmar, Philippines, Timor-Leste, Papua New Guinea, Solomon Islands, Afghanistan, Bangladesh, Bhutan, India, Nepal and Pakistan showing again a gross neglect of a health need specific to women (WHO 2008a). The average proportion of births attended by skilled health personnel stood at 77.2 per cent in the 41 Asia-Pacific countries (compared to 44 per cent for Sub-Saharan African countries in 2006). The proportion of births attended by skilled health personnel was lower than the Asia-Pacific average in South and West Asian countries (at 53.7 per cent), higher than the average in Pacific (at 89.9 per cent) and around the average in East Asia (77.8 per cent). There were substantial differences between births attended by skilled health personnel across developing (74.2 per cent) and industrialized Asia-Pacific countries (98.3 per cent). Amongst the 41 Asia-Pacific countries, Afghanistan recorded the lowest percentage of births attended by skilled birth personnel at 14 per*

cent. The highest score of 100 per cent was shared by 12 countries^{xxix}. The figures for Sub-Saharan African countries ranged from 6 per cent to 99 per cent for the same period (collated by UNIFEM 2008 based on WHO 2008a).

Box 3. Variations across class and caste in births attended by skilled health personnel

The percentage of births attended by skilled health personnel was lower amongst the bottom 20 per cent income group (22 per cent) when compared to top 20 per cent (77.1 per cent) in all the 8 countries^{xxx} on which data was available, and lower in rural (36.4 per cent) than urban areas (65.5 per cent) for the same 8 countries (WHO 2008a). In India access of women from *dalit* and tribal communities to skilled birth attendance is lower than that of other communities (Government of India 2006).

Source: WHO 2008a; Government of India 2006.

- *The proportion of low birth weight newborns, reflecting access of pregnant women to nutrition, was greater than 16 percent (the global average^{xxxi}) in 8 of the 37^{xxxii} countries for which data was available as of 2000-2006, namely Philippines, Federated States of Micronesia, Bangladesh, India, Maldives, Sri Lanka, Nepal, and Pakistan (WHO 2008a). The average proportion of low birth weight newborns was 11.7 per cent in the 37 Asia-Pacific countries, when compared to 14 per cent for Sub-Saharan Africa for the period 1998-2004 (UNICEF 2006a). The proportion of low birth weight newborns was higher than the average for Asia-Pacific in South and West Asia at 20.8 per cent, and lower than the average in East Asia at 9.9 per cent and in Pacific at 8.4 per cent. The proportion of low birth weight newborns was higher than the average at 12.4 per cent in Asia-Pacific developing countries and lower than the average at 7 per cent in the industrialized countries. Bangladesh and India recorded the highest proportion of low birth weight newborns at 30 per cent and Cook Islands the least at 3 per cent.*
- *Lack of access to abortion on demand (other than for sex selection) was evident in 35 out of 41 countries for which data was available as of 2007/2008 from Pregnant Pause database (Pregnant Pause n.d.). Women's right to abortion is an important part of their reproductive rights, when available for purposes other than sex selection. Data on legal access of women to abortion on demand) was available for 41 Asia-Pacific countries/areas from Pregnant Pause database. Abortion was legally available on demand in 6 out the 41 countries without specification of trimester, namely Cambodia, China, Democratic People's Republic of Korea, Viet Nam, Australia, and Nepal. In Bangladesh and Mongolia abortion was available on demand only in the first trimester, in Singapore up to the second trimester and in Republic of Korea with few restrictions (not specified). In the other 31 (out of 41) countries (76 per cent) women were denied abortion on demand, and had to prove grounds such as threat to life or health, mental illness, fetus abnormality, rape, or various social reasons. While the rates of sexual violence within the institution of marriage and in public spaces are significant, 26 out of 41 countries (63 per cent) do not allow for legal abortion on the grounds of rape. A greater proportion of countries in the Pacific sub-region were denied abortion on demand in general/first/second trimester and on grounds of rape than countries in other sub-regions. There was not much difference across the levels of economic development to comment on, with the ideology of the government (e.g.*

Nepal) as well as population policy (e.g. China) having a greater role. Notably, abortion accounted for the second most important known reason for maternal death in South Asia and third most important reason for maternal death in East Asia and the Pacific in 2001 (Lopez et al. 2006)

Box 4. High maternal mortality ratio (MMR) and lifetime maternal mortality risk

One of the results of lack of access to ANC, skilled birth attendance, adequate maternal nutrition, legal access to safe abortion and lack of access to emergency obstetric services^{xxxiii} is a high maternal mortality ratio. The maternal mortality ratio is higher than the WHO target of under 100 (per 100,000 births) by 2020 (World Health Assembly 1998) in 20 out of 30 countries as of 2005 and higher than the global average of 400 in 9 of the 30 countries on which data was available as of 2005 (WHO 2008a). The ten countries amongst the 30 that had already achieved the 'less than 100' target were China, Japan, Republic of Korea, Mongolia, Brunei Darussalam, Malaysia, Singapore, Australia, New Zealand and Sri Lanka. The 9 countries that recorded a maternal mortality ratio of more than 400 were Cambodia, Lao People's Democratic Republic, Indonesia, Papua New Guinea, Afghanistan, Bangladesh, Bhutan, Nepal and India. For the 30 Asia-Pacific countries, the average MMR was 302.7 as of 2005, compared with 900 for Sub-Saharan Africa as of 2007^{xxxv}. The MMR was higher than the average at 525.3 in South and West Asian countries, lower than the average in East Asian countries at 215 and Pacific countries at 182.6. The MMR was higher than the average at 335.6 in developing countries and lower at 6.3 in the industrialized countries. All the industrialized countries had reached the World Health Assembly target of a maternal mortality ratio of less than 100 by 2020. Amongst the 30 countries, Afghanistan recorded the highest maternal mortality rate at 1800 as of 2005 and Australia the least at 4 (WHO 2008a).

The picture on lifetime maternal mortality risk is slightly different from the maternal mortality ratio, as this data takes into account both MMR and total fertility rate. This data was available for 11 countries from Progress of the World's Women: 2008/2009, namely Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, Papua New Guinea, Cambodia, Lao People's Democratic Republic, Indonesia and Timor-Leste for the year 2007 (UNIFEM 2008). The lifetime maternal mortality risk was highest for Afghanistan at 1 in 8 women (that is one chance of a woman in dying in eight pregnancies) and lowest for Indonesia at 1 in 97 women. The countries that recorded a lifetime maternal mortality risk of more than 1 in 50.6 (the average for the 11 countries on which data was available) were Afghanistan, Nepal, Timor-Leste, Lao People's Democratic Republic and Cambodia. The average lifetime risk of maternal death, was higher for Sub-Saharan Africa at 1 per 37 in 2005 when compared to 1 in 1097 for East Asia and the Pacific (combined) and 1 in 86 for South Asia for the same year as per UNIFEM's Status of the World's Women, 2008/2009.

Source: World Health Assembly 1998; WHO 2008; UNIFEM 2008.

- *Fewer than 50 per cent of women had been given pap smear tests in the last one year or three years^{xxxvii,xxxviii} in 12 of the 14^{xxxix} Asia-Pacific countries^{xl} for which data was available as of 2000-2006, these 12 were China, Japan, Lao People's Democratic Republic, Viet Nam, Malaysia, Myanmar, Philippines, Bangladesh, India, Nepal,*

Pakistan and Sri Lanka (WHO 2008a). Access to pap smear tests is important for prevention and early diagnosis of cervical cancer. In only New Zealand and Australia, over 50 per cent of women had had pap-smear tests. The average proportion of women who had been tested was only 17.5 per cent in the 14 countries. The proportion was lower than the average in the 14 countries at 2.2 per cent in the 5 South and West Asian countries, 13.7 per cent in the 7 East Asian countries and higher at 69 per cent in the 2 Pacific countries (both industrialized). The proportion of women who had pap smear tests was a low 7.5 per cent in the 11 developing countries, and a much higher 54 per cent in the 3 industrialized countries. Amongst the 14 countries Bangladesh recorded the lowest proportion of women who had accessed pap-smear tests at 0 per cent and New Zealand the highest at 77 per cent. In 2001, 47,000 women died of cervical cancer in East Asia and the Pacific and 83,000 women same in South Asia, accounting for 0.7 per cent and 1.3 per cent of female deaths respectively (computed from Lopez et al. 2006).

- *Fewer than 50 per cent of women had had mammography in the past one year or three years^{xlixlii} in 12 out of 14 countries^{xliii}* for which data was available as of 2000-2006 (WHO 2008a). The 12 countries were the same as those for pap-smear, and again Australia and New Zealand were the only two countries where more than 50 per cent of women had undergone mammography. In the 14 countries of Asia-Pacific as a whole, the average proportion of women who had had a mammography was only 11.8 per cent. Only 1.6 per cent of women in the 5 South and West Asian countries had had mammography and 5.3 per cent of women in the 7 East Asian countries had had mammography. On the other hand 60 per cent of women in the 2 Pacific countries (both industrialized) had had mammography. The proportion of women who had accessed mammography was a low 3.8 per cent in the 11 developing Asia-Pacific countries for which data was available and higher at 41 per cent in the 3 industrialized Asia-Pacific countries. Amongst the 14 countries, Myanmar, Bangladesh and Pakistan recorded the lowest proportion of women who had accessed mammography at 1 per cent, and New Zealand recorded the highest at 63 per cent. Access to mammography is important for early diagnosis of breast cancer, which increases survival chances. In South Asia there were 76,000 female deaths due to breast cancer in 2001 (accounting for 1.17 per cent of female deaths), while in East Asia there were 93,000 deaths due to the same reason (accounting for 1.5 per cent of female deaths in that year). No case of deaths due to breast cancer amongst men was reported -- it is a rare but not impossible occurrence.
- *Access to ovarian cancer screening is also limited.* Its incidence is only slightly lower than the other two types of cancers specific to females. 25000 women died of ovarian cancer in 2001 in East Asia and Pacific and 21000 in South Asia in the same year (Lopez et al. 2006)

Specific health needs of men

The specific health needs of men arising out of intersection of sex and gender include services for treating hydrocele, penile cancer, prostate cancer and sexual dysfunction. While it is men's biological sex that exposes men to these health conditions (women do not suffer from the same), it is the construction of dominant masculinities that leads to many men's failure to learn about their bodies or look after them, coupled with a tendency to seek health services at the last minute. It has been reported that many men feel that worrying about their

health would be an indication sign of “femininity” (Instituto Promundo 2002; Goldie n.d). Further, men’s sex-specific health needs have been neglected by providers, and preventive/screening measures are not part of essential service packages in most Asia-Pacific countries. In the past decade there has been considerable attention to targeting preventive sexual health messages for men, but often these have been limited to promoting safe sex services and preventing the spread of HIV/AIDS.

- *Prostate cancer*^{xliv}. In 2001, 21,000 men died of prostate cancer in South Asia, and the disease accounted for 3 per cent of deaths amongst men in that year (computed from Lopez et al. 2006). In East Asia and the Pacific (combined) the comparative figures are 16,000 men dying of prostate cancer constituting 2.3 per cent of all male deaths during the same year (ibid 2006). Prostate cancer affects 1 in every 12 men over the age of 50. After the age of 40, it is advised that all men should have regular medical examinations for prostate cancer. When diagnosed early, prostate cancer has a high cure rate but when neglected it becomes incurable and leads to death. (Instituto Promundo 2002).
- *Sexual dysfunction*^{xlv}: Sexual dysfunction can take the form of erectile dysfunction, premature ejaculation and retarded ejaculation^{xlvi}. The number of males affected by erectile dysfunction was estimated to be 80.9 million in Asia in 1995, with the number of males affected being projected to increase to 199.9 million by 2025. The age-adjusted prevalence rate of erectile dysfunction was estimated at 22 per cent in Malaysia and 34 per cent in Japan in 2005, with the rate increasing with age (Nicolisi et al. 2003).
- *Testicular cancer*: Testicular cancer accounts for 1 per cent of all cancers in men globally and is the most common form of cancer among men in the age group 15 to 35 years of age (Instituto Promundo 2002) There is no country, sub-regional or regional data on incidence of testicular cancer in Asia-Pacific, however it is known to be higher amongst Caucasians than Asiatics. The incidence of testicular cancer is higher in New Zealand (information on Australia was not available), and lower in Asian countries (Urology Channel 1998). Testicular cancer occurs in only one of the testicles and once removed has no impact on the sexual and reproductive functions of the man. Testicular cancer is relatively easy to treat, particularly when detected in the early stages, through self examination^{xlvii}. Such self-examination training to detect cancer in early stages is neglected in sexual and reproductive health awareness camps (Instituto Promundo 2002).
- *Penile cancer*:^{xlviii} Penile cancer accounts for 20to 30 per cent of all cancers in men living in Asia, with the incidence higher in developing countries than industrialized ones (Stanford Cancer Center 2009). Lack of adequate hygiene (in the case of the poor, partly due to lack of access to sanitary water and toilet facilities) is one of the greatest causes of cancer of the penis. Male circumcision reduces the risk of penile cancer. When discovered in the early stages, cancer of the penis can be cured and easily treated. If left untreated or caught late, it can spread to internal organs and cause mutilation or death (Instituto Promundo 2002; Stanford Cancer Center 2009)

Specific health needs of sexual/gender minorities

There is little research on specific health problems of lesbians, gays, bisexual, transgender and inter-sexed people, and virtually no cross-country data on the extent to which these have been addressed. The exception is research into the high incidence of HIV amongst gay and bisexual men and strategies for combating HIV amongst men who have sex with men (Lee 2000). The available literature points to sex-specific health issues which vary with whether the person is lesbian, gay, transgender or inter-sex. These concerns are rarely addressed in sexual and reproductive health education or in terms of inclusion of preventive and curative measures in public facilities.

- *Specific health needs of inter-sex persons.* Inter-sexed people are those who are born with indeterminate genitalia, and may need access to genital surgery. However, such facilities are not easily available in public health facilities in several of the developing Asia-Pacific countries.
- *Specific health needs of transgender people.* A section of transgender people may seek to undergo sex reassignment treatment. The process of gender reassignment is long and involves psychiatric, endocrinology, and surgical evaluation. The process of hormone therapy is required before any surgical procedure. In addition to the risk of liver abnormalities with estrogen use, there is also the rare possibility of pituitary tumor. For female-to-male transgender persons, androgen therapy carries an increased risk for heart disease, endometrial hyperplasia, and subsequent endometrial carcinoma. Gender reassignment surgery may cause sexual dysfunction. Those who use hormone therapy but decide not to undergo surgery continue to be at risk for endometrial cancer (female-to-male persons) and prostate cancer (male-to-female persons) (Lee 2000).
- *Specific health needs of gay and bisexual men.* Gay and bisexual men practice anal or/and oral intercourse. Anal-receptive intercourse is associated with an increased risk of infection with HIV, human papillomavirus, hepatitis B virus, and herpes virus. Anal and oral insertive intercourse is strongly associated with inflammation of the urethra, risk of HIV and gonorrhea infection. People who practice anal-receptive intercourse and are infected with HIV have a greater risk of developing anal cancer than men with HIV practicing vaginal intercourse (Lee 2000). While some heterosexual men also practice anal intercourse, the proportion of gay and bisexual men practicing anal intercourse is greater.
- *Specific health needs of lesbians.* Lesbian women tend to less use oral contraceptives than heterosexual women, and may be more vulnerable to breast cancer (Lee 2000). Lesbians may require artificial insemination services if pregnancy is desired, but such services are not offered in public health facilities in developing Asia-Pacific countries. There is also an assumption amongst lesbians and health providers that certain diseases common amongst heterosexual women, such as cervical cancer or HIV through sexual intercourse, do not affect them. However, this is not true, as human papillomavirus and HIV can be transmitted through vaginal secretions (Lee 2000).

Box 5. Cost effectiveness vs. specific health needs of women, men and sexual/gender minorities

The principles of ‘public good’ and ‘cost-effectiveness’ rather than health rights largely determines what health services are provided free of cost. Based on these principles, the essential health packages in the World Development Report 1993, ‘Best buys’ package of the World Bank, 2000, and the WHO 2000 list of interventions with a large potential impact on health (all based on principles of cost effectiveness) address several of the health needs of women and men in the area of prenatal and delivery care, family planning, STDs and AIDS (see Castillo et al. 2005; World Bank 1993; WHO 2000b), but exclude several other important health needs that are specific to individual women, men and sexual and gender minorities which do not fall under the public good umbrella. As a result commitments made under the General Comment 2000 to the ICESCR on rights of all to the highest standards of health are not met. Some of the important sex/gender specific needs that are not addressed are: screening and treatment for breast and cervical cancer, health responses to gender-based violence (for women irrespective of sexual orientation), prostate, penile and testicular cancer (for men irrespective of sexual orientation), anal cancer (in particular, for men who have sex with men); assisted reproductive technologies for lesbians; sex reassignment surgery for transgender people. The case of the “Essential health package” in Bangladesh under the Health and Population Sector Programme (Phase I-1999-2003) is an example. The programme includes only family planning, emergency and essential obstetric care, prevention and control of STDs and HIV/AIDS, control of communicable diseases, child health, limited curative care (for accidents and injuries) and behaviour change communication; it ignores specific health needs of sexual/gender minorities, men and even women other than maternal health and family planning (Arrows for Change 2003; Jahan 2003) Behavioral change messages do not address the diverse sex-specific needs of different groups.

Source: World Bank 1993; WHO 2000b; Arrows for Change 2003; Jahan, 2003; Castillo et al. 2005.

4.1.3 Gender and rights violations

Gender-based violations of human rights (including sexual and reproductive rights) which have a bearing on health can be found in almost all countries

A third type of gender and health inequity arises not merely through ignoring sex/gender specific health needs, but through outright violations of human rights (including sexual and reproductive rights) which have a bearing on the health of women, girls and sexual/gender minorities. For each example, regional and sub-regional performance, developing and industrialized country performance and details of marked underperformance are given below.

Sexual and reproductive rights violations against women and girls

- *Females have a lower chance of being born in 6 out of 21^{xlix} Asia-Pacific countries for which data on sex-ratio at birth was available.* The Global Gender Gap Report, 2008 of the World Economic Forum compares the sex-ratio of the country with the normal sex-ratio at birth of 0.94 (World Economic Forum, 2008). The 6 countries out of 21 which have a sex-ratio of below 0.94 (year unspecified) are India (.89), China (.90), Republic of Korea (.93), Viet Nam (.93), Malaysia (.93), and Singapore (.93).

The rest recorded a sex-ratio of 0.94 (World Economic Forum 2008). By comparison, none of the 24 of the 45 Sub-Saharan Africa on which data was available recorded sex ratios at birth below 0.94 (World Economic Forum 2008). These data indicate a marked son preference in the 6 countries cited above and prevalence of sex selection before birth (either during pregnancy or at the point of conception). A smaller number of the female population contributes to higher age gaps between spouses, trafficking of girls and at times to several brothers marrying one wife. India and China both have legislation prohibiting sex selection, but it is not clear if the other countries have such legislation (ARROW 2005).

- Gender inequity in rates of malnutrition and access to preventive health care amongst children and adults: Country data on malnutrition in children and adults by sex was difficult to come by. The assessment, *Situation of Women and Children in Nepal, 2006* by UNICEF Nepal notes that 45 per cent of children were underweight and 43 per cent showed stunted growth; and more girls than boys are malnourished with regard to height and weight-for-age indicators, while more boys show low weight-for-height indicators. The same report notes lower rates of full immunization of girls than boys, with 48 per cent for the poorest girls, compared with 56 per cent for the poorest boys (UNICEF 2006b). The NHFS 2005-6 in India, while not providing sex-disaggregated statistics on the nutrition of children, observes that the body mass index of 33 per cent of women is below normal, when compared with 28 per cent in the case of men. The proportion of both women and men whose body mass index is below normal is higher in rural areas and among those with no education (who tend to be poorer) (Government of India 2006). Rates of anemia and forms of malnutrition amongst adolescent girls and adult women (15-49 years) are high in Bangladesh, Nepal and India for which data was available, but there was no comparative data on prevalence of anemia and malnutrition amongst adolescent boys to make a comparison (ARROW 2008). The rate of anemia amongst pregnant women was a high 51 per cent and 57.9 per cent in Bangladesh and India in 2004 and 2005-6 respectively (ARROW 2008; and Government of India 2006). By contrast, gender inequity in malnutrition among disadvantaged girls was not observed in Sub-Saharan Africa (Haddad et al. 1996).
- Early marriage amongst girls and violation of rights to childhood and sexual rights: Data on early marriage amongst girls, a violation of the rights of girls in general, and their sexual rights when the marriage is forced as in parts of South Asia, was available for 21 countries¹ (all developing) from the OECD database on Gender, Development and Institutions (OECD 2009). The data indicates that the incidence of early marriage was 15.9 per cent in the 21 Asia-Pacific countries (year unspecified), and present to some degree in all 21 countries. However, the same data base suggests that the prevalence of early marriage (15-19 years) in Asia-Pacific is lower than in Sub-Saharan Africa where the incidence of early marriage was 28.9 per cent in 37 countries on which data was available. Amongst the 21 Asia-Pacific countries the incidence of early marriage was highest in South and West Asia at 27.3 per cent and least in East Asia at 9.3 per cent, with countries of the Pacific falling in between at 15.5 per cent. The incidence of early marriage was highest in Bangladesh at 48 per cent and lowest in Singapore and China at 1 per cent (year unspecified). Although early marriage is legally banned in most countries of the region, religion-based personal laws are ambiguous in some countries (Center for Reproductive Rights 2004 2005; ARROW 2005, 2008).

- Adolescent fertility (15-19 years), leading to adverse reproductive health outcomes: Comparative data on adolescent fertility rates was available for 26 countries^{li} from World Health Statistics, 2008 for the period 2000 to 2006 (WHO 2008a). In the 26 countries of Asia-Pacific as a whole, the average adolescent fertility rate was 45.7, when compared to a rate of 118 for Sub-Saharan Africa as of 2007 (World Bank n.d.). The adolescent fertility rate was higher than the Asian average at 77.3 in South and West Asian countries and lower at 32.1 in East Asian countries and 30.7 in Pacific countries for the period 2000 to 2006. The adolescent fertility rate was higher at 49.5 in developing countries and lower at 16.3 in industrialized countries for the period 2000 to 2006. The adolescent fertility rate (see definition) was highest in Afghanistan at 151 and lowest in Republic of Korea at 2.
- Women do not have full decision-making power over reproduction and women bear the burden of contraception in several Asian countries.* The government, men and older relatives often determine the number of children women should have and when they can have them. While most countries of the region have adopted anti-natalist population policies, some such as Mongolia have adopted pro-natalist policies and others like Singapore have adopted an ethnically based policy where some communities are encouraged to have more children and others fewer (Center for Reproductive Rights 2004, 2005). The anti-natalist policies of China have resulted in the promotion of forced abortion after the birth of a first child (Center for Reproductive Rights 2005), yet another concern is who bears the burden of contraception. According to the ICPD+10 monitoring report covering nine countries, it is women who bear the burden of contraception in these countries -- India, China, Pakistan, Nepal, Indonesia, Cambodia, Malaysia and Philippines (ARROW 2005). To illustrate, NFHS 3 2005-6 provisional data for India indicates that the contraceptive prevalence rate was 56.3 per cent for all methods and 48.5 per cent for modern methods of contraception (Government of India 2006). Female modern methods (male sterilization and condoms) accounted for 13 per cent of modern contraceptives, and male methods (female sterilization, intra-uterine devices and pills) accounted for 87 per cent of modern contraception (ibid 2006).
- Physical and sexual violence against women in domestic and public spaces.* Country statistics on prevalence of domestic violence are not easy to come by. WHO conducted a study on domestic violence covering 10 countries including Japan, New Zealand, Bangladesh, Samoa and Thailand in the Asia-Pacific region. The study rated the prevalence of 'ever experienced' physical or sexual domestic violence at 15 per cent in Japan (1 per cent during pregnancy), 24 to 42 per cent in New Zealand (no data during pregnancy), 35 to 54 per cent in Samoa (10 per cent during pregnancy), 53 to 62 per cent in Bangladesh (10-12 per cent during pregnancy), and 41 to 47 per cent in Thailand (4 per cent during pregnancy) (WHO, 2005b, 2005c, 2005d, 2005e, and 2005f). A study on domestic violence by ICRW in India, cited in UNIFEM 2003 in its report 'Ending Violence Against Women', found the reported incidence of violence in India to be 40 - 66 per cent, with higher rates in urban slums and amongst those with no schooling (UNIFEM 2003). The same publication stated that in Asia-Pacific the incidence of reported violence varied from 10 per cent in the Philippines to 67 per cent in Papua New Guinea (UNIFEM 2003). However, the low reported figures of domestic/intimate partner violence in Japan and Philippines (and amongst educated women in India) needs to be viewed with skepticism as there is a culture of silence on reporting domestic /intimate partner violence. The WHO study also

suggests that physical and sexual violence against women in public spaces, taking the form of sexual harassment, molestation, rape, trafficking etc., is also common, though not as high as domestic violence (WHO 2005b, 2005c, 2005d, 2005e, and 2005f).

- Prevalence of customary practices that are harmful to women's and girls' health and sexual and reproductive rights: While some customary practices in the region are beneficial to women's health (e.g. long periods of breast feeding which reduces vulnerability to breast cancer), there are several that are not. Data from the Global Gender Gap Report 2008 on 18 Asia-Pacific countries^{lii} indicates a prevalence of female genital mutilation in Malaysia, Indonesia and Pakistan (Women's Economic Forum, 2008). The same report notes a higher prevalence of FGM in Sub-Saharan Africa (present in 18 of 23 countries on which data was available). The Reproductive Health Organization notes that some communities in India practice female genital mutilation as well (Reproductive Health Organisation 2005). There appears to be no law in these countries against female genital mutilation (UNIFEM 2003). In parts of China, India and Republic of Korea the practice of female infanticide occurs occasionally even though legally punishable. In parts of South Asia as well as Vanuatu and Papua New Guinea the practice of forced marriage is not rare, and girls have little choice with regard to the partner (Griffen 2006). In Kiribati, girls upon marriage are expected to prove their virginity on consummation of the marriage, failing which they are ostracized (Griffen 2006). Another customary practice that is harmful to women's health is the practice of dry sex (removal of vaginal fluid with absorbent materials) which removes sexual pleasure for women (Reproductive Health Organisation 2005). In parts of the Philippines, there is severe restriction placed on women's weight gain during pregnancy, which leads to poor maternal health (Reproductive Health Organisation 2005). In other instances, particular groups of women such as dalits (untouchables) in parts of Karnataka, Andhra Pradesh and Maharashtra in India are supposedly married to a local God, but in practice exploited sexually by upper castes. These are just a few examples of how some harmful customary practices affect women's/girls' health and sexual and reproductive rights. Some of these practices are sanctioned by conservative religious forces who interpret religious texts out of context, to justify discriminatory practices.

Box 6. Health consequences to women and girls of sexual and reproductive rights violations

- The practice of FGM frequently leads to severe bleeding, problems in urinating, and later to childbirth complications, fistula and other disabilities of the mother, and increased chances of newborn deaths (WHO 2008b).
- Child bearing in the age group 15-19 years doubles the rate of deaths due to pregnancy-related complications compared to pregnancies in adult women, increases the rate of neonatal mortality and also increases the total fertility rate (Adhikari 2003).
- Physical and sexual violence against women and girls is one of the important reasons for mental illness amongst women (WHO 2002). Extreme forms -- such as causing burns and injuries -- can lead to death. Sexual violence can further lead to genital and other injuries, sexually-transmitted infections including HIV/AIDS,

pelvic pain and pelvic inflammatory disease, urinary tract infections, unwanted pregnancy, unsafe abortion and even death (UNFPA 2000).

- Physical and sexual violence against pregnant women is one significant cause of maternal mortality (UN 2006)
- Dry sex can lead to painful intercourse for women (Reproductive Health Organization 2005)

Source: UNFPA 2000; WHO 2002; Adhikari 2003; Reproductive Health Organization 2005; UN 2006; WHO 2008b.

Sexual and reproductive rights violations of gender and sexual minorities

Data on legalization of homosexuality was available for 39 (for males)/38 (females) of the 42 Asia-Pacific countries^{liii} as of 2008 from Wikipedia (Wikipedia 2008). The data indicates that only 17 countries (45 per cent) had legalized homosexuality for both males and females. These countries include Cambodia, China, Hong Kong China, Japan, Republic of Korea, Lao People's Democratic Republic, Mongolia, Viet Nam, Indonesia (other than the province of Aceh), Philippines and Thailand in East Asia, Australia, Marshall Islands, New Zealand, Niue, and Vanuatu in the Pacific, and Nepal in South Asia. In another 7 countries (18 per cent of countries) female homosexuality is not considered a crime under the law, but male homosexuality is criminalized. These countries include Singapore, Tuvalu, Tonga, Nauru, Kiribati, Fiji, and Cook Islands. There was no country where female homosexuality is criminalized but male homosexuality is not. Altogether, in 24 of 38 Asia-Pacific countries (63 per cent) female homosexuality is not a crime, while in only 17 out of 38 Asia-Pacific countries (45 per cent) is male homosexuality not criminalized. That is, in this respect norms on dominant masculinities are stronger than those on dominant femininities. A total of 14 of 38 (37 per cent) countries ban both female and male homosexuality. These include Afghanistan, Bhutan, India (under dispute), Sri Lanka, Pakistan, Maldives, Islamic Republic of Iran in South and West Asia, Papua New Guinea, Samoa and Solomon Islands in Pacific, and Democratic People's Republic of Korea, Brunei Darussalam, Malaysia and Myanmar in East Asia. All three industrialized countries in Asia-Pacific have legalized homosexuality, while the developing countries in Asia-Pacific are lagging in this area. In particular, governments of developing countries in the South and West Asian sub-regions are most conservative on their stands, East Asia is more liberal, with the Pacific falling in between. Information on whether countries where homosexuality is legal permit same-sex marriage is available for 16 of 17 countries that permit both female and male homosexuality (Wikipedia 2009). With the exception of Nepal, none of the countries recognize same-sex marriage. There is no data on whether countries where only female homosexuality is not a crime allow same-sex marriages.

Apart from legal discrimination, sexual and gender minorities are discriminated against in society. Cases of being thrown out of house or village when LGBTI people reveal their identity are not uncommon. Transgendered and inter-sexed people often end up eking out a livelihood through sex-work. Lesbians and gays are at times forced into heterosexual marriage in parts of South Asia. An ethical issue in the case of inter-sexed minors is whether parents have a right to opt for genital surgery (and choose one sex over another) on their own when a child is under 18 years of age. In Asia, the poor cannot afford genital surgery in private hospitals and leave the children to grow as they are, and these constitute another

group suffering discrimination. Wealthy parents, however, may opt for genital surgery (Warner and Bhatia 2006).

While instances of sexual violations against heterosexual boys are less frequent than violations against women and girls, they nevertheless exist. In tourist spots in Asia-Pacific, boys from poor households may be compelled into prostitution for survival.

4.1.4 Social Construction of Masculinities and Gender Differentials in Health

Gender norms lead to different health outcomes for women, men and sexual/gender minorities

There are gender norms that disadvantage men which are not necessarily considered gender discrimination, but arise from the construction of dominant masculinities, where the transition from adolescence to adulthood is associated with consumption of tobacco, drinking alcohol, fast driving, boarding running buses, having sex with multiple partners and substance use (WHO 2002, 2003a). These unhealthy behaviours adversely affect men's health, and the health of women who relate with them (Nessa et al. 2008). However, the gap between men and women who use tobacco and other substances is lower amongst the younger generation than the older.

- *Gender norms lead to higher current tobacco use amongst adult males than females in 27 of the 28 Asia-Pacific countries^{liv} for which data was available, and more adversely affect the health of adult males as of 2005 (computed from WHO 2008a). The lone country where tobacco consumption was higher amongst adult females than adult males was Nauru in the Pacific. In New Zealand and Australia the current prevalence of tobacco use was only slightly higher amongst adult men than adult women (the female-to-male ratio for tobacco use was over 0.75 in both these countries). In the 28 countries the ratio of adult female-to-male current tobacco use was 0.27. The ratio of female-to-male current tobacco use was higher in the case of the Pacific (0.50), below the average in South and West Asia (0.24), and below the average in the case of East Asia (0.15). Amongst the 28 countries the female-to-male ratio in current tobacco was least in the case of Malaysia at 0.051 and highest in Nauru at 1.1 in 2005. In the case of adolescents tobacco use amongst females is increasing rapidly, and the ratio of female-to-male tobacco use amongst adolescents stands at 0.62 for 30 countries for which data was available for the year 2005 (WHO 2008a). In New Zealand and Cook Islands a greater proportion of adolescent girls use tobacco than boys. The female-to-male ratio in tobacco use was more than 0.75 in Republic of Korea, Fiji, Federated States of Micronesia, Samoa, Tuvalu, and Bangladesh (WHO 2008a). Tobacco use by men and women adversely affects their health and is one of the contributing causes of tuberculosis, lung cancer and oral cancer. In women it increases chances of cervical cancer as well (Sen et al. 2007).*

Box 7. Adverse health consequences for men of unhealthy behaviour arising out of gender norms

Women are more 'biologically' exposed to HIV transmission from men to women through heterosexual sex (WHO 2003b). However, gender norms lead to higher incidence of HIV amongst males than females (15-49 years) in 17^{lv} (61 per cent) of 28 Asia-Pacific countries for which data was available (year unspecified) from the State of the World's Population, 2007 with the incidence^{lvi} similar in 10^{lvii} (36 per cent), and greater amongst females in one -- 3 per cent (Democratic People's Republic of Korea) (UNFPA 2007). The HIV prevalence rate was highest for males in Papua New Guinea at 1.8 (followed by Thailand at 1.7) and for females in (Democratic People's Republic of Korea) at 1.6 (followed by Thailand and Papua New Guinea at 1.2). While it is difficult to compute averages (as figures are not specific), the HIV prevalence rates seem slightly higher in East Asia than South and West Asia (with the exception of India and Nepal), and for developing compared with industrialized countries. As data was available on few Pacific countries it is difficult to comment on the sub-region. The higher prevalence of HIV amongst males than females (15-49) years may not hold true for the age group 15-24 years, where prevalence amongst females is higher than males as of 2007 according to the World Development Indicators database (0.2:1 in East Asia and Pacific and 0.3:1 in South Asia) but not as stark as in Sub-Saharan Africa (3.3:1)(World Bank n.d.)

Mortality due to tuberculosis and road traffic accidents is higher for men than women in both East Asia and the Pacific and South Asia (Lopez et al 2006, on behalf of the World Bank). However, all men may not be equally vulnerable to tobacco use, substance use and excess alcohol consumption. According to micro studies from India, Indonesia, Samoa and Papua New Guinea men from low-income groups engage in the above practices more than those from middle/high-income groups. Inability to perform socially accepted roles as breadwinners may drive men to adopt harmful practices (Ng et al. 2007 Nasir and Rosenthal 2008, Sorensen et al 2005, Neufeld et al. 2005, Mishra et al. 2005). This may not apply to road accidents. Evidence from Afghanistan and Samoa suggests that road accidents are higher amongst young men irrespective of income groups (Sugerman et al. 2005, Lippe et al. 2008).

Source: Lopez et al. 2006 ; Mishra et al. 2005 ; Nasir and Rosenthal 2008 ; Ng et al. 2007 ; Neufeld et al. 2005 ; Sorensen et al. 2005 ; WHO 2008a.

- *Gender norms lead to greater acceptance of multi-partner sex amongst men than women.* Data on legal acceptance of polygamy is available for 17 Asia-Pacific countries^{lix}(all developing), which indicates that the practice of polygamy is prevalent in 8 of the 17 countries namely Indonesia, Malaysia, Bangladesh, India, Islamic Republic of Iran, Nepal, Pakistan and Sri Lanka from the Global Gender Gap Report, 2008 (World Economic Forum, 2008). The nine countries where polygamy was not reported were China, Japan, Democratic People's Republic of Korea, Viet Nam, Myanmar, Philippines, Thailand, Australia and New Zealand. According to the report, the acceptance is greater (0.63) in South and West Asia and less in East Asia (0.13). As only two countries were covered in the Pacific it is difficult to generalize. Polygamy is noted to be higher in Sub-Saharan Africa than Asia-Pacific by the same report (the practice is reported to be prevalent in 20 of 22 Sub-Saharan African countries on which data is available). However, the acceptance of polygamy needs to be distinguished from acceptance of multi-partner sex, which is high in several parts

of East Asia and the Pacific as well. Griffen (2006) observes that multi-partner sex amongst men is common in Kiribati, Tonga, Vanuatu, Papa New Guinea and Samoa.

4.1.5 Gender, Health Financing, and inequities in access to Healthcare

Although the economic ability of women to pay for health services is lower, they pay for health services according to their economic capacities and not according to their need for services in at least 36.6 per cent of 41 Asia-Pacific countries for which data was available (WHO 2008).

- *In 36.6 per cent of 41 Asia-Pacific countries for which data was available^{lx}, the proportion of public expenditure on health to total health expenditure was below 50 per cent as of 2005 (WHO 2008a). In these countries, females may find it more difficult to pay for private health services than men as they earn less, and most of the private expenditure is in the form of out-of-pocket payments^{lxi} (WHO 2008a). These countries include Cambodia, China, Indonesia, Lao People's Democratic Republic, Myanmar, Malaysia, Philippines, Singapore, Viet Nam, Afghanistan, Bangladesh, India, Nepal, Pakistan and Sri Lanka. Public expenditure was more than private health expenditure in all the 15 Pacific countries for which data was available, while the reverse was true in the case of 6 of the 9 (66.7 per cent) of the South and West Asian countries (with the exception of Maldives, Bhutan and the Islamic Republic of Iran). The case of East Asian countries fell in between, with 9 of the 16 (56.3 per cent) countries recording higher private than public expenditure on health. Public expenditure was 75.5 per cent of total expenditure in industrialized Asia-Pacific countries, 57.9 per cent in developing Asia-Pacific countries, and 61.0 per cent in the region as a whole.*
- *As part of health sector reforms, several countries have introduced user fees in public facilities in Asia-Pacific. To give an example, user fees have been introduced in 6 of the 8 Pacific developing countries (studied by WHO) in the last decade wherein public expenditure has been traditionally higher than private health expenditure. These countries include Fiji, Papua New Guinea, Vanuatu, Cook Islands and Federated States of Micronesia. The Government of Tonga and Samoa have been cautious in the past about introducing user fees, though Samoa has recently stated an interest in such fees (WHO, 2008c). In Cook Islands, user fees are applicable for people in the age group 17 to 60 years (ibid, 2008a). While it is too early to comment on the impact of user fees on gender and economic inequities in health, experience from Andhra Pradesh in India suggests that user fees could have a gender-differentiated impact. With an increase in user fee revenues earned by a sample of 219 public sector hospitals managed by Andhra Pradesh Vaidhya Vidhana Parishad from Rs 3.062 million in 2001/2 to 7.751 million (\$69591 to \$176159 at Rs 44 to a US\$) in 2003/04 the proportion of deliveries in hospitals accounted for by the poor declined from 74 per cent to 53 per cent during the same period, and the proportion of surgeries accounted for by the poor declined from 82 per cent to 74 per cent. That is, in general utilization by the poor declined and the utilization of delivery services decreased even more, indicating that the introduction of user fees has a gender-differentiated impact. Though user fee exemptions were supposed to have been in place for the poor, these were not effectively operational (Mahal and Veerabhraiah 2005).*

- *Universal social insurance exists in only a few countries, which is important given that majority of women workers are engaged in the informal sector (see next section).* In a study on health financing in 8 Asian countries (Bangladesh, India, Sri Lanka, Philippines, Thailand, Indonesia, China and Viet Nam) universal social insurance was provided in only one, Thailand (Ravindran 2005). Following economic reforms in the 1980s, China dismantled its commune-level prepayment cooperative medical scheme, which had been partly subsidized by the government. The dismantling of the prepayment scheme affected maternal and reproductive health services adversely, aside from family planning services which continued through another delivery stream. However, a scheme was reintroduced in 1998 through the World Bank supported Health VII project in 71 poor counties out of approximately 2400 counties (ibid 2005). The impact on women's health in these counties is not clear. On the whole it is not surprising that social security expenditure as a percentage of total government health expenditure is only 12.7 per cent for 40 countries^{lxiii} for which data was available as of 2005, with the percentage much higher in the East Asia at 24.5 per cent and much lower than the average in Pacific at 2.3 per cent and about average in South and West Asia at 11.6 per cent (WHO 2008a). Social security expenditure as a percentage of total government expenditure was 12.3 per cent in developing countries and 39 per cent in industrialized countries as of 2005.
- *Coverage of the poor in general and of poor women by private health insurance is minimal, and many private insurance packages do not cover important health needs of women and gender/sexual minorities.* Private health insurance as a percentage of total private health expenditure was only 4.4 per cent for 40 Asia-Pacific countries for which information was available for 2005 from the World Health Statistics, 2008 with 80.9 per cent being out-of-pocket expenditure. Further, private health insurance normally does not cover several health service needs that affect women such as institutional deliveries or treatment for morbidities arising from gender-based violence. Neither are specific needs of sexual/gender minorities such as sex reassignment surgery or genital surgery covered. (Ravindran 2005; Murthy and Ravindran 2005). Quite often private insurance does not cover preventive health services. It is not clear whether male-specific cancers are covered through private insurance.

4.2 Impact of gender inequities in the economy on gender inequities in health

Gender inequities in the economy have a bearing on gender inequities in exposure to health risks, ability to access health care, compliance with treatment, and on violations of sexual and reproductive rights in work place. These often adversely affect the health of women, sexual and gender minorities, and men in risky occupations. Five pathways that link gender inequities in the economy and health can be identified, which are elaborated in this section.

4.2.1 Pathway 1

The gender division of labor results in heavy work load and greater health risks for women/girls and different occupational health risks for women/girls and men/boys

- *Gender differences in work load and women's health:* Data on total work hours in market and non-market activities was available for five countries for the period 1997 to 2005 from the Human Development Report 2007/2008 namely India, Republic of

Korea, Japan, Australia and New Zealand. The data indicates that in all five countries women work longer hours than men on a typical day, with the difference being least in the case of New Zealand (3 minutes more) and highest in India (1 hour and 6 minutes more). In Australia, women work 17 minutes more than men, in Japan women work 30 minutes more than men, while in Republic of Korea women work 39 minutes more (in rural areas 36 minutes more). That is, gender differences in work load are not automatically less in industrialized countries, with much depending on gender norms. Japan is reported to impose rigid gender norms and hence it is not surprising that the work load of women is much more than that of men, when compared with New Zealand or Australia. Though the work load of women is higher than that of men, in all countries the proportion of time spent by women on market activities is significantly less than that of men (other than in rural parts of Republic of Korea. Non-market activities include fetching water, cleaning and cooking, taking care of children and the elderly and taking care of the sick and people with disability. The heavier work load of women leads to greater musculoskeletal problems (including during pregnancy) and less time to access health care services (WHO 2000a). In Nepal, the heavy work load of women in the hill and mountain areas in the immediate post-delivery period leads to a high incidence of uterine-prolapse (UNICEF 2006b) The work load of women in Sub-Saharan Africa may be heavier than in Asia-Pacific, as in the former women have less access to improved water and sanitation facilities, and their economic participation rates are higher.

- *Gender division of tasks and different health risks for women and men:* 30.5 per cent of women in 20 Asia-Pacific countries^{lxiii} for which information was available from the Human Development Report were engaged in agriculture, 16.5 per cent in industries and 51.6 per cent in services for the period 1995-2005 (computed from UNDP 2007). The comparative figures for Sub-Saharan Africa are 67.3 per cent, 7.1 per cent and 25.3 per cent respectively as of 2007 (UNIFEM 2008). Further, in Sub-Saharan Africa women also played a major role in managing food crops in Asia. The figures for 17 developing Asia-Pacific countries (35.1 per cent, 17.1 per cent and 46.1 per cent respectively) are different from industrialized ones (4.3 per cent, 12.7 per cent and 83 per cent respectively), with a greater proportion in agriculture in the case of the former. A greater proportion of women workers are engaged in agriculture in South and West Asia than in East Asia (information was available on few Pacific countries). As observed by Ostlin (2002), there is a strong division of labor in each of these sectors. In agriculture, women in much of Asia-Pacific were responsible for tasks such as weeding, transplanting, and winnowing, while men were responsible for tilling the land and irrigation. Harvesting was done by both women and men. The weeding and transplanting work that women do involves bending for long periods of time leading to back pain and water-borne diseases (WHO 2000a). Similarly, there is a division of tasks/roles in industrial occupations. A study of women in the garment industry in Fiji noted that women had to sit in a fixed position and do repetitive jobs, and that they suffered from body pains, obesity, bladder and kidney problems. Fewer men are engaged in the garment industry, and most are engaged in supervisory posts; in general, they did not face similar problems (Chand 2006). In the service sector, where the proportion of women is increasing in Asia-Pacific countries, there are occupational health risks as well. Women in night shifts in business process outsourcing offices experience considerable stress and experience changes in their menstrual cycles. At times the gender division of task disadvantages men's health. Men who dominate the mining sector, for example, were found to suffer from high

rates of respiratory infections, mercury poisoning or to have lower body mass index than men in other occupations in China and Thailand. The few women in mining had even lower body mass index than men (Du et al. 2008). Men who were involved in deep sea fishing had a high rate of cataract problems and headaches (WHO 2006a)

4.2.2 Pathway 2

Intra-household biases against females in distribution of food or education expenditure or health care expenditure leads to greater health risks for women and girls and less access to health care in several Asia-Pacific countries.

- *Intra-household biases in food allocation lead to gender differences in nutrition status.* There is no country data on gender bias in allocation of food. A review of literature on intra-household food distribution by the International Food Policy Research Institute covering India, Bangladesh, Nepal, and Pakistan in South Asia and Philippines in South-East Asia (apart from other developing countries) noted that in South Asia, of 24 studies comparing food and protein intake of males and females, 11 showed a pro-male bias, 4 showed a pro-female bias and 9 showed no bias. Less gender bias in food allocation was observed in Pakistan. In India, boys were also prioritized in breast feeding. There was no trend of decreasing inequity in food intake with a rise in income, although inequity is greater in poor households during lean periods. In the Philippines, of 16 studies, 8 show a pro-male bias, none show a pro-female bias and the rest reveal no bias. Gender bias was however more prominent amongst adults than children in the Philippines (Haddad et al. 1996). The same study noted no gender bias in food allocation in Sub-Saharan Africa (ibid 1996).
- Park and Rukumnuaykit note gender bias in food allocation against girls in China as well, with fathers in poor households cutting their food intake when boys are born but not when girls are born (cited in Gammaage 2006). Studies in the Pacific have noted that in Papua New Guinea, girls were given less food than boys, while in Fiji it is women who eat last (Griffen 2006). It is hence not surprising that data from South Asia and the Pacific suggest that malnutrition rates are higher amongst females than males amongst children, anemia rates are higher amongst females than males and that body mass index of adult women is less than that of men (see section on gender inequities in health).
- *Intra-household inequalities in education expenditure and gender inequities in health:* There was little country data on intra-household expenditure on education by sex. An indirect indicator^{lxiv} is gross enrollment at primary, secondary and tertiary schooling. Data as of 2005 from the Human Development Report, 2007/2008 suggests that there is a gender bias against females in primary enrolment in 9 countries out of 30^{lxv}, in secondary enrolment in 16 countries out of 30^{lxvi} and at tertiary levels in 9 countries out of 26 for which data was available. The pattern was similar to the regional trend in developing countries, while in industrialized countries no gender gap was seen at primary levels, but gaps were seen at other levels (UNDP 2007). In absolute terms, female gross enrolment was 105 per cent at primary levels, but only 71 per cent in secondary levels and 27 per cent at tertiary levels in the Asia-Pacific countries for which data was available (developing countries, 104.9 per cent, 64.9 per cent and 19.8 per cent respectively). Gross enrolment at secondary and tertiary levels for females (as well as males) was lowest in South and West Asia and highest in East Asia, with

the Pacific countries falling in between. This may imply that a substantial proportion of girls are vulnerable to early marriage in South and West Asia and the Pacific. (Selvaratnam 1988). It may also imply that girls need to contribute to household tasks, other discrimination etc. The gender gap disadvantaging girls in primary, secondary and tertiary gross enrolment is higher for Sub-Saharan Africa when compared with Asia-Pacific for 2005, and absolute levels of female primary, secondary and tertiary enrolment are lower at 92 per cent, 28 per cent and 4 per cent respectively (UNDP 2007).

- *Intra-household biases in health care expenditure lead to less access of females to treatment for health conditions.* There is little country data on gender bias in health care expenditure. A study of urban households in Bangladesh observed that girls suffering from severe diarrhea were less likely to be seen by a licensed allopath (adjusted for income), while in rural households female children suffering from diarrhea were less likely to receive an antibiotic (Larson et al. 2006). A study in rural China covering 5057 people noted that females were more likely to go blind as a result of cataract, corneal opacity and glaucoma all of which were treatable, than men, (Li et al. 2008). In Papua New Guinea, a study of 4348 people noted that distance to health facilities was a deterrent to seeking health care, with differences observed across age and sex. Attendance decreased markedly with a distance of 3.5 kilometers and above. Female patients showed higher distance decay during infancy, but less distance decay in adolescence and adulthood when compared with males (Müller et al. 1998).

4.2.3 Pathway 3

Gender inequities in earned income, control over household income, and ownership of assets mean that women have less cash-in-hand for health care expenditure

- *Gender inequalities in earned income:* Data on 29 Asia-Pacific countries^{lxviii} from the UNDP's Human Development Report 2007/2008 indicates that the ratio of female-to-male earnings was only .52 (year unspecified) and there was no country in which females earned as much as or more than males (computed from UNDP 2007). Data was not available by age, marital status or occupation. The comparative figure was 0.6 for 24 Sub Saharan African countries on which data was available from the Global Gender Gap Report, 2008 (World Economic Forum 2008). The same report indicates that female economic activity rates as a percentage of male economic activity rates was 67.6 per cent for 32 Asia-Pacific countries^{lxix} for which data was available, indicating the potential for gender disparities in wages^{lxx}. The comparative figure for Sub-Saharan Africa was 73 per cent as of 2005 (UNDP 2007). Disaggregating data for Asia-Pacific further, the ratio of female-to-male earned income was lowest at 0.41 in South and West Asia and highest in the Pacific at 0.58, and falling in between in East Asia at 0.53. In developing countries, the ratio of female-to-male earned income was 0.51 and in industrialized countries was 0.62. The countries where female IMR is higher than or the same as male IMR and where under-five female mortality was higher than or the same as male under-five mortality correspond with countries where females earn 52 per cent or less of what males earn, other than Viet Nam and China (where the one-child population policy may have a role to play). Countries where female healthy life expectancy at birth is lower or similar to that of male rates coincide with countries where female earnings are 52 per cent or below male

earnings. For a few countries data on earnings were not available to make this comparison^{lxxi} The fact that earned income of females was lower than that of males made women and girls in poor women-headed households particularly vulnerable to sexual exploitation, with some compelled into prostitution to supplement family income and others trafficked for similar purpose (some of whom were sold by their family members) As noted in section 2, a study in the Philippines revealed that as women's earnings increased, their nutritional status and that of their children improved (WHO 2008d).

Box 8. Low levels of income, women compelled into prostitution and HIV/AIDS in Cambodia and India

A study from Cambodia which interviewed 20 women in the garment industry <http://www.ncbi.nlm.nih.gov/pubmed/12216990> reported that they were all from low-income- backgrounds and their families depended on their earnings. As they were paid such low salaries, these women stated that they were pushed into prostitution to supplement income. They were subjected to physical violence, alcohol and substance use, both self-taken and forced, and receive meager wages. The prevalence of HIV amongst women in the garment industry was noted to be high (Nishigaya 2002).

A study by Sarkar et al. (2008) of 580 women compelled into prostitution in Eastern India (from India, Bangladesh, Nepal and Bhutan) noted that one in four had been trafficked; including some sold by their own poor family members without their knowledge. Physical and sexual violence on entry to the work was higher among those trafficked than among those who had joined knowingly. Overall condom use with the last two clients was only 38 per cent. The incidence of HIV/AIDS was higher amongst trafficked women.

Source: Nishigaya 2002; Sarkar et al. 2008.

- *Gender inequalities in control over household income and gender inequities in health:* Country data on control over household income was not available. A micro-level study commissioned by UNDP in the early 2000s found links between control over income and access to skilled birth attendance. The study observed that women who were part of self-help groups (SHGs) *which had received training on gender and social issues* exercised greater control over their income and had greater access to skilled birth attendance than non-members with similar economic and education status when the group started. The study covered 157 poor women who were not members of SHGs and 293 members who were members of SHGs which were formed under the South Asia Poverty Alleviation Program. Only 31 per cent of non-members exercised full or major control over their income and only 19.5 per cent over their husbands' income. Only 45 per cent of those who had undergone delivery in the last three years had access to skilled birth attendance. In contrast, amongst members of the UNDP-initiated South Asia Poverty Alleviation programme who were in the same income group when they joined the group, 52 per cent reported having control over their income and 46 per cent over their husband's income. Of members who had delivered in the last three years, 68 per cent had access to skilled birth attendance. While the income of programme members was 1/6th more than the income of non-member households, the percentage of skilled birth attendance was nearly 40 per cent more amongst members; indicating that control over their own and their spouse's income

could play an important role in improving women's access to health care. This aspect merits further investigation, as access to health information could also have played a role (Murthy et al. 2005). Similar positive benefits in women's access to health services were noted in Uttar Pradesh when micro-credit interventions are linked with gender inputs -- including an emphasis on women's control over their income (GEAG 2004).

- *Gender inequalities in land ownership and health rights violations against women:* The OECD Women, Gender and Institution database <http://webnet.oecd.org/wbos/index.aspx>, provides data on male preference in inheritance of land for 14 Asia-Pacific countries (year unspecified). The report gives a score of 0-1 for equity in gender preference in inheritance with a score of 0 denoting equity and 1 denoting high levels of male-preference inequity. According to this scoring, male preference in inheritance is absent or low (less than or equal to 0.2) in Myanmar, Thailand, Fiji, Sri Lanka, Philippines, Indonesia and China and is strongly present (score of 0.7 and above) in Bangladesh, Islamic Republic of Iran, Pakistan, Malaysia, India, and Nepal; with Viet Nam falling in between (0.5). But the classification of China as scoring low in China in the light of evidence of the light of evidence from secondary literature to the contrary. . Though this database did not cover several Pacific countries, Griffen (2006) notes that traditional equal land rights of women and men were eroded under European colonization and now in several Polynesian Pacific countries land is owned by men. A joint study of 502 married women in Kerala, India by the Institute of Economic Growth and Center for Development Studies observes that those who own land faced less domestic violence than women who did not. As many as 49 per cent of the women who owned neither land nor house suffered long-term incidence of physical violence, compared with 18 per cent and 10 per cent respectively of those who owned either land or a house, and 7 per cent of those who owned both. The percentage of women facing violence who left the violent situation was much higher among the propertied (71 per cent) than among those without property (19 per cent). Few propertied women returned after leaving. Dowry harassment by husbands or in-laws was also lower amongst women with property (InfoChange News and Features 2003). Gender inequalities in infant and under-five mortality rates are not present in the countries scoring low on male preference as the per the World Health Statistics, 2008 (WHO 2008a). The reverse is true in the case of the countries wherein male preference in inheritance prevails (other than Islamic Republic of Iran). Land ownership in Sub-Saharan Africa varies, with Malawi, Mozambique, Tanzania and Zambia following matrilineal inheritance systems (under threat with individual registration process), Lesotho and Swaziland following patrilineal inheritance system, and several promoting clan ownership (Benschop 2004). However, women have access to their own land in Sub Saharan Africa for cultivation of food. Bride price rather than dowry is the norm in most of the Sub-Saharan countries.

4.2.4 Pathway 4

Low and unequal presence of women in the work force in the formal sector means they have less access to health insurance/security than men while working, and less access to means to pay for health care services and to meet their health needs

Almost all women like men in agriculture in Asia-Pacific work in the informal sector. Data on employment in the informal sector as a percentage of non-agricultural employment for the period 1998-2002 was available from the Human Development Report, 2007/2008 for four Asia-Pacific countries: Indonesia, Philippines, India and Pakistan (UNDP 2007). The data indicates the presence of a slightly greater proportion of women than men in non-agriculture in the informal sector, other than in Pakistan; where the proportion of men in non-agricultural in the informal sector was higher than that of women. On average, 68 per cent of women in non-agriculture were in the informal sector in these four countries, with the proportion being higher for Indonesia and Philippines and lower for India and Pakistan (UNDP 2007). Taken together with the agriculture sector, a majority of women workers in developing Asia-Pacific countries work in the informal sector. Though this is also true for men workers, the proportion of men in the informal sector is slightly lower given that they are slightly less often engaged in agriculture than are women (37 per cent of women workers vs. 35 per cent of men workers). This increases gender inequities in access to health care especially in those countries where private expenditure on health as a proportion of total health expenditure is higher than public health expenditure, which is the case in 36.6 per cent of Asia-Pacific countries.

4.2.5 Pathway 5

Women's and gender/sexual minorities' specific health needs are rarely taken into account in the work place, and rarely does the work place promote parenting roles of males.

- *Maternity leave:* Given that women workers are mainly engaged in the informal sector in developing Asia-Pacific countries, they are not eligible for maternity coverage from employers. Data from the Global Gender Gap Report, 2008 provides details on the period of maternity leave provided for by law in 19^{lxxii} Asia-Pacific countries in the formal sector (World Economic Forum 2008). The data suggests that on an average, women are legally eligible for 3.0 months of paid maternity leave in these 19 Asia-Pacific countries, with the period being 2.9 months in developing countries and 3.5 months in industrialized countries. The number of months of paid maternity leave was slightly higher in the Pacific at 3.0 months when compared with South and West Asia at 2.8 months (information was available only on Pacific industrialized countries, which makes the figure artificially high). Amongst the 19 countries, the number of months of paid maternity leave ranged from 1.7 months in Nepal to 5 months in Viet Nam, where a greater proportion of women belong to unions. The number of months of maternity leave was lower than Viet Nam at 3.5 months in Japan and New Zealand. That is, levels of economic development of a country do not guarantee increase in paid maternity leave; the sensitivity of the government to maternal health needs of women as well as women's presence in trade unions makes a difference. This is equally true of parental leave, with Australia scoring a low 1 out of a possible 15 on the Gender Equality Index (in parental leave), Japan scoring 5 and New Zealand 8; and all three ranking below the average figure for 21 industrialized countries. The scores may be lower if one takes into account the actual practice of men availing themselves of parental leave, and taking care of children (Ray et al 2008).
- *Data on the amount of paid maternity leave for those in the formal sector was available for 19^{lxxiv} Asia-Pacific countries from the Global Gender Gap Report, 2008 (World*

Economic Forum 2008). On average, by legislation 90.6 per cent of the wage was supposed to be provided in the 19 countries during the maternity leave period. The proportion of salary paid during the maternity period was higher in South and West Asia (94.5 per cent) than in East Asia (86.8 per cent). (Information was only available on industrialized countries of the Pacific, which makes the figure artificially high). The percentage of maternity leave paid was higher in developing countries (91.4 per cent) than in industrialized countries (80 per cent). That is, the higher the numbers of months of maternity leave, the lower the proportion of salary paid by law. Fourteen countries mandated 100 per cent payment of maternity leave, namely China, Republic of Korea, Indonesia, Malaysia, Singapore, Philippines, Viet Nam, New Zealand, Niue, Pakistan, India, Bangladesh, Nepal, and Sri Lanka.

- *In the formal sector (and even less so in the informal sector), there is no policy of taking into account the sex-specific health needs of women or sexual/gender minorities beyond socially sanctioned motherhood.* To give an example, single women live-in heterosexual couples and lesbian couples who choose to have a child are rarely allowed maternity leave or benefits in several developing Asia-Pacific countries. In some countries, maternity leave is rarely given for married couples who adopt. Seldom is extra leave available for miscarriages or induced abortion (where legal), and in fact there is a taboo about discussing miscarriages and abortion in several countries. There is no provision for reduced travel for women employees during the first two days of monthly menstruation when the flow may be heavier. In low-paid jobs such as stitching in the garment sector, there are restrictions on how many times women can use toilets, while observers report that men supervisors take frequent breaks for smoking^{lxxv}. Sexual/gender minorities, in the rare instances that they find work in the formal sector, do not get paid leave or receive health benefits for sex assignment surgery or for availing themselves of assisted reproductive technologies.

4.2.6 Pathway 6

There are direct violations of the right to health and sexual rights affecting women, sexual/gender minorities in the work place and men/women with stigmatized illnesses.

- *Mental, physical and sexual rights violations in the work place:* Though there is little global/UN/data site/country data on incidence of sexual harassment against women, boys and gender minorities at the work place, harassment is not uncommon in Asia-Pacific countries. Human Rights Watch (2008) notes that millions of women from Asian countries including Indonesia, Sri Lanka, the Philippines, and Nepal migrate to Saudi Arabia, Kuwait, the United Arab Emirates, Lebanon, Singapore and Malaysia as legal or illegal domestic workers. Most countries exclude domestic workers from protection under their labor laws, leaving domestic workers with little remedy against exploitative working conditions. Authorities in both receiving and sending countries receive thousands of complaints of labor exploitation or abuse each year. While most cases involve unpaid wages, food deprivation, and long working hours with no rest, a significant number of cases include allegation of verbal, physical, and sexual abuse. But many cases are never officially reported, due to domestic workers' confinement in private homes, lack of information about their rights, and employers' ability to deport them before they can seek help. The psychological and sexual health of migrant domestic workers is an important issue (Human Rights Watch 2008).

- *Mental violence against sexual and gender minorities in the work place:* While data on the incidence of discrimination against gender and sexual minorities in the work place is hard to come by, there is perhaps no country in Asia-Pacific where no discrimination is found. Discrimination takes the form of not being given employment (if orientation is disclosed), being asked to leave work if the employer finds out their sexual/gender identity, not being allowed to use female/male toilet once their gender orientation is known, and being denied medical expenses for any health needs specific to them. All these lead to considerable stress and stress-related morbidity such as high blood pressure (GayJapanNews et al. 2008). See Box 9 for an example.

Box 9. Discrimination against transgender person in Japan

A male-to-female transgender woman was working for a publisher when she decided to disclose her identity. She asked her employer to recognize her as a woman in January 2002. In March 2002, she began going to the office in women's clothes. Her employer ordered her not to wear women's clothes and to stay at home. However, she continued to wear women's clothes to her office. Her employer fired her in April 2002. The woman subsequently filed a lawsuit and won the case in June 2002. The Tokyo District court found that the initial dismissal of the case was unjust. However, there is no legislation against discrimination of gender minorities in the work place, leading to considerable agony and stress for the majority of gender minorities in Japan.

Source: GayJapanNews et al. 2008.

4.3 Impact of gender inequities in health on gender inequities in the economy

Gender inequities in health impact gender inequities in the economy through five pathways discussed below.

4.3.1 Pathway 1

Health morbidities and stigma from gender/sexual-based violence force women who were previously working to lose their jobs or prevent them from going out and work.

There is little information on the impact of gender/sexual-based violence against women on their work force participation, participation in group economic activities, or earnings of women, and virtually no cross-country data on this issue. However, micro studies from Uttar Pradesh, India indicate that fear of increased domestic violence is one of the reasons why some women do not join economic programs initiated by the government or NGOs (Gorakhpur Environment Action Group 2004). Disfigurement through gender-based violence could lead to women opting to drop out of work, as was the case of some of the adult women^{xxvi} survivors of acid violence in Bangladesh. Public ridicule was not uncommon. (Acid Survivors' Foundation/Save the Children Sweden Denmark 2005). Even women professionals in the formal sector, when subject to harassment at the work place by their husbands or ex-partners, are at times given a warning by their employers not to ruin the 'work atmosphere' and reputation of their company .

4.3.2 Pathway 2

Poor access to controversial and low priority sexual and reproductive health services, even where legal, leads to loss of income for women, men and sexual/gender minorities.

Some reproductive health services, even when legal, are not easily available in public health facilities. A case in point is abortion, which is available on demand in only 6 out of 42 Asia-Pacific countries for which information was available. Women hence have to make repeated visits to public health facilities to prove either that their life is at risk, or that they have been raped, or that there is abnormal development of the fetus. Hence many go to private providers, often providing unsafe abortion at high costs. Women seeking abortion lose considerable time, earnings and at times assets, affecting their long-term economic security (Potdar et al. 2008). Other health services required by women are less controversial, but not easily available in public health facilities in developing Asia-Pacific, and hence even the poor have to access these from providers at considerable cost and loss of earnings. A case in point is infertility services for women and men, which are not available in many low- and middle-income developing countries such as India, Bangladesh, Nepal, Pakistan, Cambodia, and Lao People's Democratic Republic. This may also be true of men with testicular, penile or prostate cancer, screening and testing of which is not part of essential service packages. Such loss of income may also be true in the case of poor trans-gender persons who need treatment for unsafe castration/emasculation though this aspect has been little studied.

4.3.3 Pathway 3

The high expenditure of men on tobacco and alcohol in poor households in several countries leads to lower contributions by men for household needs, and lessens the ability of women to use part of their income to improve their enterprises.

As mentioned in the section on gender inequities in health, tobacco, excess alcohol and substance use amongst males is higher than amongst females, and according to a few studies higher in poor households than economically well off households due to greater economic stress. Such unhealthy behavior reduces men's economic contribution to the household, and in extreme cases women have to run the household purely with their own earnings. In worst cases, men who are addicted to substances demand part of women's earnings for their habits. As a result, poor self-employed women who live with partners who are prone to tobacco use, substance use, and excess alcohol consumption are rarely able to invest in expansion of their enterprises.

4.3.4 Pathway 4

Loss of employment of men and women living with HIV

It is not uncommon for men and women living with HIV in Asia-Pacific to be dismissed when an employer finds out about their condition. Laws protecting against such discrimination are not common in most Asia-Pacific countries. A study in Indonesia, Philippines, India and Thailand carried out in 2003 covering 753 HIV-positive respondents revealed that one in five people reported some discrimination within the workplace setting. The Philippines cohort experienced the highest proportion of workplace discrimination, with people losing their jobs (33 per cent), or with job description or duties being changed (44 per cent), or losing prospects for promotion (21 per cent). The study unfortunately did not

examine whether men or women living with HIV suffered greater work place discrimination. Such discriminatory practices cause considerable mental agony, and increase inability to pay for treatment (Paxton n.d).

4.3.5 Pathways 5

Loss of access of women to housing and land when husbands die of stigmatized conditions such as AIDS

In parts of South Asia wives are blamed when men die of HIV or tuberculosis. At times they are denied access to land and houses owned by their husbands. Such economic violations are higher when wives are found to be HIV positive. HIV-positive women have little access to resources for their own treatment (Swaminathan et al. 2007). In the case that the wife dies first from communicable diseases, the widower is not denied access to the few assets such as jewels which she may have owned.

4.3.6 Pathways 6

Gender inequities in DALYS due to gender differences in mortality and morbidity

The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability (due to morbidity or physical disability) is referred to as DALY (disability-adjusted life year). Though the concept of DALY has come under criticism from a gender lens as it places value on cost-efficiency and overlooks the rights to health of women, marginalized men and sexual/gender minorities (see Castillo et al. 2005 for a critique), data produced by the World Bank on mortality and burden of diseases disaggregated by sex, age and two sub-regions^{lxviii} provides interesting insights (Lopez et al. 2006 on behalf of World Bank).

- Total DALY from all causes is slightly higher for females than males in South Asia, but not East Asia and Pacific.
- Gender inequities in infant, child and adolescent health and poor maternal health in several South Asian countries and the greater mortality of South Asian females in the 0-4, 5-14, 15-29 and 80+ years age groups leads to a greater burden of diseases of females than males in these age groups. In the case of East Asia and Pacific (combined) this holds true only for the 80+ age group.
- In both regions the burden of diseases due to childhood cluster diseases, maternal conditions (including abortions), dengue, meningitis, nutritional deficiencies, trachoma, sexually transmitted diseases (other than HIV), sense organ disorders, and musculoskeletal diseases was higher for females than males.
- The global burden of disease is higher for males than females with regard to peri-natal conditions, tuberculosis, HIV/AIDS, Hepatitis C, digestive disorders, leprosy, genitourinary diseases, unintentional and intentional injuries.

However, the burden of particular diseases may not take into account co-morbidities and the burden of these co-morbidities. For example, pulmonary tuberculosis in pregnant women increases the risk of obstetric morbidity. Genital tuberculosis in women can lead to infertility

(Sen et al. 2007). It is also not clear whether burden-of-disease calculations take into account sex differences in effectiveness of treatment for diseases, which in turn may lead to greater burden of some diseases for women than men. To give an example, women undergoing anti-retroviral treatment are more vulnerable to adverse side effects such as skin rashes, liver toxicity and mitochondrial toxicity than men (Forum for Collaborative HIV Research 2002).

Like East Asia and the Pacific (combined), total DALY from all causes is higher for Sub-Saharan males than females. However, this does not hold true for the age groups 15-29, 60-69, 70-79 and 80+ years where the reverse is true. Another important sex/gender difference compared with Asia-Pacific is that the burden of HIV/AIDS is higher amongst Sub-Saharan females than males, while the burden of nutritional deficiencies is higher amongst Sub-Saharan males than females (Lopez et al. 2006).

5. UNDERLYING CAUSES: LACK OF POWER, VOICE AND ACCOUNTABILITY

Underlying gender inequities in health and gender inequities in the economy are three causes:

- *Unequal distribution of power* between women and heterosexual men and between sexual/gender minorities and heterosexual men and women in societal institutions. Heterosexual men who do not subscribe to dominant construction of masculinities are another group with little power in society.
- *Unequal voice and agency of women and sexual/gender minorities*, and that of heterosexual men who wish to challenge dominant construction of masculinities.
- *Weak accountability of power holders* in institutions of society, namely households, communities, markets and the state to address gender inequities in health and the economy

Amongst the disempowered groups, the poor, ethnic and religious minorities, single women, *dalits*, the differently abled, migrant populations and those living with stigmatized diseases occupy a particularly disadvantaged position.

This section elaborates on the three causes, and at the end gives examples of the vicious cycle in operation between gender inequities in health, gender inequities in the economy and lack of power, voice and accountability

5.1 Unequal distribution of power based on gender

- *Unequal distribution of power in households*: The unequal distribution of power in households is reflected, for example, in the social construction of men as household heads, and women's lesser decision making power over their lives (ARROW 2008). Data from Progress of the World's Women, 2009 on decision making by women on their own health reveals stark inequalities in how much control married women have in these areas in South Asia. According to the report, 54.2 per cent of married women in South Asia have no say over decisions on their own health, 25.7 per cent take decisions jointly and only 19.4 per cent of women take decisions on their own. The situation is better in East Asia and the Pacific (combined) where the comparative figures are 7.4 per cent, 29 per cent and 63.3 per cent. The comparative figures for

Sub-Saharan are 51.2 per cent, 19.3 per cent and 29.4 per cent, which suggests that women have greater decision making authority on health in this sub-region than South Asia, but not as much as in East Asia and the Pacific (UNIFEM 2008).

Unmarried women in both the Asia and Pacific regions have greater say over decision making on health than do married women (UNIFEM 2008). The fact that half of all surveyed women do not have any say over decisions on their health in large parts of South Asia leads to delays in access to emergency health services. Such delays are one of the important causes of high maternal deaths in several countries in South Asia (see ARROW 2008). Delays may also be one of the reasons for higher death rates due to sexually transmitted diseases amongst females than males in South Asia but not in East Asia and the Pacific (Lopez et al. 2006, commissioned by World Bank). However regional aggregation needs to be viewed cautiously, as decision making power may be higher in Sri Lanka than the South Asian average and lower in China, Japan and Republic of Korea than the East Asia and Pacific average. Weak decision making power in South Asia is closely linked to patrilineal inheritance and patrilocal residence systems, as well as the practice of dowry where the bride's side has to pay money or goods to the groom's side during marriage (discussed in 2.2.3). In contrast, in Sub-Saharan Africa the system of bride price is common and women have access to land for food crops, although inheritance patterns vary (Blumberg, 2004).

- *Unequal distribution of power in community:* There is little cross-country data on who dominates traditional community institutions. In large parts of the Pacific, during the post European colonization period, women lost their rights to joint community decision making with men (Griffen 2006). In Kiribati, it is now men who make decisions in traditional community meetings (ibid 2006). Male dominance in decision making is also true of large parts of India, Bangladesh, Pakistan, Afghanistan and Islamic Republic of Iran where men from dominant economic and social groups take decisions in village councils and community councils. Rigid moral policing of women and girls by male leaders of traditional institutions continues, ranging from virginity testing at marriage in Kiribati, to violence against couples if they marry outside their caste in India, and flagging of women who have been raped on the grounds of adultery in Pakistan, though recently made illegal (Griffen 2006; Sen et al. 2007).
- *Unequal distribution of power in market and state:* Women occupy few senior positions in parliaments or as female legislators, senior officials and managers, as well as in local self governance institutions (with a few country exceptions). Country data from the Human Development Report, 2007/2008 on the proportion of seats in Parliament held by women was available for 28 of the 42 Asia-Pacific countries (UNDP 2007).^{xxix} Consolidation of this data reveals that only 13.5 per cent of the seats in parliaments in the 28 countries were held by women (year unspecified). This figure is lower than the proportion of women in parliaments in Sub-Saharan Africa which stands at 17 per cent as of 2007 (World Bank n.d.). Within Asia-Pacific the percentage of women in parliament is higher in countries of East Asia at 16.8 per cent and lower in countries of the Pacific and South and West Asia both at 10.7 per cent. Comparatively, the proportion of women in parliament was greater in industrialized countries than in developing countries (23.9 per cent and 12.3 per cent), although the proportion of women in Japan is closer to the developing country average. While data on the percentage of women in local self governance institutions was not available for

all countries of the Asia-Pacific region, it ranged from 2 per cent to 33 per cent in 12 countries in 2000^{lxxx} (Drage 2001). While there is little data on the power of sexual and gender minorities in societal institutions, few hold political decision making positions in the region. Women's presence in economic and political decision making provides a role model for younger women. Further, there may be health benefits of having women in local self-governance institutions, particularly for women. Drage (2001) observes (in a review of reports on 12 countries) that women leaders in local governments prioritize improving water, sanitation and health services more than men in such positions. Better water and sanitation services have a greater impact on women's health than that of men's given the division of labor, and their need for safe toilets. Further, women leaders were found to spend greater time to address issues of gender-based violence than men leaders at the local level (Drage 2001). More poor women (though still a minority) are found in local self-governance institutions when compared with parliaments, where the few women who occupy positions of power usually come from economically powerful groups.

The percentage of female legislators, senior officials and managers was only marginally better than the proportion in parliament for the 20 countries for which this information was available from the Human Development Report 2007/8. It was 23.4 per cent for the region as whole, higher in the Pacific at 25.8 per cent, and lower in South and West Asia at 14.2 per cent (data was available only in Pacific industrialized countries, which raises the Pacific average to 36.5 per cent). Again the performance of industrialized countries (27.7 per cent) was slightly better than developing countries (22.6 per cent), with Japan coming close to the developing country average. While hard data is difficult to obtain, it is mainly women from privileged economic and social backgrounds who dominate the few decision making positions in economic spheres as well. Whether women's presence in economic leadership makes a difference to gender equity in economy is a moot question. Women are found more in Scandinavian countries in decision making positions, and these are the countries with better maternal and parental leave policies (UNDP 2007; Ray et al. 2008).

5.2 Unequal voice and agency

Not only do women, sexual/gender minorities and men who question alternative masculinities rarely occupy decision making posts, but they are rarely consulted by power holders in community, state or market institutions.

Unlike countries in Latin America, few countries in Asia-Pacific have passed legislation on the right to participation in public policy determination. A study on community participation in health sector reforms in Asia-Pacific in the late 1990s/early 2000s notes that few health sector reform projects were designed by the World Bank and governments based on consultations with women's rights groups, groups working on behalf of sexual and gender minorities or people's health movements. A notable exception was the Bangladesh Health and Population Sector Strategy, but nevertheless, consultations with sexual/gender minorities does not appear to have been undertaken (Jahan 2003).

It is important that women, men who represent alternative voices (to dominant masculinities), and sexual/gender minorities have a say in public policy formulation, and it is equally important that they are aware of their rights and are willing to challenge deeply entrenched gender norms. The NFHS 2005-06 surveys in India, for example, revealed that 38 per cent of

married women with no sons preferred to have more children even when they already had two daughters (Government of India 2006). Studies on wife beating covering Cambodia, Bangladesh, India and Nepal note that acceptance of wife beating amongst women ranged from 29 per cent in Nepal to 57 per cent in India (Rani and Bonu 2008)

Since the 1990s, poor women in Asia-Pacific have been mobilized under micro-credit SHGs, with the proportion of women in SHGs varying across countries and within countries. In some countries they have been federated at village levels. While this mobilization has created spaces for women to meet collectively, access loans, have their own savings, better access health services, and push gender norms a little; they have not been able to dramatically alter power relations at household, community, local market or local government levels. However, this mass-scale mobilization of women offers the potential for challenging power relations, if groups are encouraged to combine micro-finance with gender empowerment interventions (Deshkmukh-Ranadive and Murthy 2005). Another important route is strengthening women's participation and leadership in trade unions, which is low in the region. According to Women of the World 2009, the proportion of women workers in labor unions in Asia ranged from 31 per cent in Viet Nam to 4 per cent in the Philippines, averaging 11.5 per cent for eight Asian countries^{lxxxii} for which data was available for the period 1994-2004 (UNIFEM 2008). Female-to-male earned income was highest in Viet Nam amongst the eight countries (UNDP 2007).

5.3 Weak accountability of power holders

Weak accountability of power holders with regard to gender equity in health and the economy is another issue.

- *Accountability of state to gender equity in health and economy:* Though 24 of 41 Asia-Pacific countries^{lxxxiii} for which data was available had ratified/acceded to ICESCR and 36 of 41 had done so with regard to CEDAW (compared with 46 of 48 Sub-Saharan Countries, cited in UNIFEM 2008), few had passed legislation on right to health, right to livelihood or right to gender equity (computed from <http://www2.ohchr.org/english/bodies/ratification/3.htm>). The Indonesia is one of the few exceptions which have passed a law on right to health (ARROW 2008). See Table 4 and 5. Unless a country guarantees right to health, right to livelihood or right to gender equity, it is difficult for women to demand accountability of the state for gender equity in health or the economy. While National Women's Commissions exist in some of the Asia-Pacific countries, they do not generally have judicial powers, nor autonomy from the ruling political party. Often they focus on issues of gender-based violence; however their emphasis on other gender equity health economic issues is less. National Human Rights Commissions have greater judicial powers in some countries, but do not focus much on gender equity in health or the economy, or rights of sexual/gender minorities (Asia-Pacific Forum on National Human Rights Institutions 2002).

Table 4. Ratification of ICESCR by Asia-Pacific countries as of October 2008

No.	Country	Ratification/ accession/
	North-East	8/8
1	Cambodia	*
2	China	*
3	Japan	*
4	Korea, Democratic People's Republic of	*
5	Republic of Korea	*
6	Lao People's Democratic Republic	*
7	Mongolia	*
8	Viet Nam	*
	South-East	4/8
9	Brunei Darussalam	
10	Indonesia	*
11	Malaysia	
13	Myanmar	
14	Philippines	*
14	Singapore	
15	Thailand	*
16	Timor-Leste	*
	Pacific	4/16
17	Australia	*
18	Cook Islands	
19	Fiji	
20	Kiribati	
21	Marshall Islands	
22	Micronesia, Federated States of	
23	Nauru	
24	New Zealand	*
25	Niue	
26	Palau	
27	Papua New Guinea	*
28	Samoa	
29	Solomon Islands	*
30	Tonga	
31	Tuvalu	
32	Vanuatu	
	South and West Asia	8/9
33	Afghanistan	*
34	Bangladesh	*
35	Bhutan	
36	India	*
37	Iran, Islamic Republic of	*
38	Maldives	*

39	Nepal	*
40	Pakistan	*
41	Sri Lanka	*
Grand Total		24/41

Source: <http://www2.ohchr.org/english/bodies/ratification/3.htm> Date accessed October 24th, 2008

Table 5. Ratification of CEDAW by Asia-Pacific countries as of October 2008

No.	Country	Ratification/ accession/ succession	Ratification/ accession/ succession Optional protocol
North-East		8/8	2/8
1	Cambodia	*	
2	China	*	
3	Japan	*	
4	Korea, Democratic People's Republic of	*	
5	Republic of Korea	*	*
6	Lao People's Democratic Republic	*	
7	Mongolia	*	*
8	Viet Nam	*	
South-East		8/8	3/8
9	Brunei Darussalam	*	
10	Indonesia	*	
11	Malaysia	*	
13	Myanmar	*	
14	Philippines	*	*
14	Singapore	*	
15	Thailand	*	*
16	Timor-Leste	*	*
Pacific		12/16	3/16
17	Australia	*	
18	Cook Islands	*	
19	Fiji	*	
20	Kiribati	*	
21	Marshall Islands	*	
22	Micronesia, Federated States of	*	
23	Nauru		
24	New Zealand	*	*
25	Niue		
26	Palau		
27	Papua New Guinea	*	
28	Samoa	*	
29	Solomon Islands	*	*

30	Tonga		
31	Tuvalu	*	
32	Vanuatu	*	*
	South and West Asia	8/9	4/9
33	Afghanistan	*	
34	Bangladesh	*	*
35	Bhutan	*	
36	India	*	
37	Iran, Islamic Republic of		
38	Maldives	*	*
39	Nepal	*	*
40	Pakistan	*	
41	Sri Lanka	*	*
Grand Total		36/41	12/41

Source: <http://www2.ohchr.org/english/bodies/ratification/3.htm> Date accessed October 24th, 2008

- *Accountability of markets to gender equity in health and economy:* there are few mechanisms to hold market institutions accountable to gender equity in health and the economy; especially when the majority of poor women in developing Asia-Pacific countries are engaged in the informal sector with no clear employers. Strengthening gender-aware health and social security coverage for informal sector workers is a challenge. While labor laws stipulate maternity leave and health benefits with contributions of employers for formal sector employees, they are weak on what health issues are covered under health benefits. Controversial (e.g. abortion) and costly services (e.g. treatment of couples for infertility or of gender minorities for sex-change surgery) are rarely covered under health benefits (Murthy and Ravindran 2005). Laws have little to say on coverage of health needs of sexual and gender minorities by employers. Further, regulations to promote accountability of the private health sector are limited. With over 50 per cent of people dependent on the private health sector in 36.6 per cent of Asia-Pacific countries this is an important problem.
- *Accountability of traditional community leaders:* There is little information on how countries regulate the decisions of traditional community leaders on gender, health and economic issues. This is a matter worth researching. During the 2004 tsunami, NGOs found that there were no laws to regulate the functioning of traditional *Panchayats* in coastal Tamil Nadu, which distributed more relief to households with males engaged in deep-sea fishing and paying taxes than to those headed by women without male members engaged in deep-sea fishing (Save the Children 2006). Such economic inequities can have an adverse effect on the health of women heading households and their children.
- *Accountability of male household heads:* Accountability of male household heads to gender equity in health and the economy is another issue. According to UNIFEM (2008) while 6 of 9 governments in South Asia have legislation on domestic violence,

6 of 9 do not have legislation on marital rape. In East Asia and the Pacific the situation is worse: 15 of 27 countries do not have a law on domestic violence and 24 of 27 have no law on marital rape. Cross-country data on gender equity in legislation on inheritance was not available, indicating how little governments attempt to hold male household heads accountable to leave land equally to women. Legislation is not the only route to promoting accountability of male household heads. Awarding men on International Women's day who have adopted positive practices like supporting women who are survivors of violence seems a good strategy as is being attempted in Bangladesh^{lxxxiii}.

5.4 The vicious circle in operation in Asia-Pacific

As explained in the framework in section 2.0, the inter-linkages between the three elements -- lack of power, voice and accountability, gender inequities in health, and gender inequities in economy -- are not uni-directionally linear, but operate as a vicious circle with each element reinforcing the other two. This vicious circle at its most benign can lead to further deepening of the three elements and in its worst form can lead to death of the person. Women, girls and sexual/gender minorities are affected more adversely than men through this vicious loop. Some real life examples illustrate this:

Sexual and gender minorities in Malaysia are vulnerable to social and legal prosecution and violence. This shows their lack of power in society and vis-à-vis the state. Transgender people in Malaysia can be detained under either the civil laws as well as the Syariah Criminal Offences Act (religious laws), showing how state and religious institutions come together to oppress gender minorities. Muslim transgender people (in particular male to female) are regularly arrested under the Syariah Criminal Offences Act for 'wearing women's clothes for immoral purposes' and are fined US\$200 to US\$800 or imprisoned. Non-Muslims on the other hand are fined US\$7-14 under the civil laws (Kasim 2008). Such heavy fines on Muslim transgender people could plunge them into poverty, or further deepen their poverty and push them into prostitution for survival.

Kalpna, a school girl aged 16 from Taratal, Bardiya, Nepal, from a lower middle class farming family loved a boy in senior grade school and had a physical relationship with him. They had no idea about contraception (as there was no sexual and reproductive education available), and she became pregnant. That is, neither the government nor the community leaders were accountable for providing SRH education to adolescents. Her family and community members forcibly married them. The adolescents, thus, did not have a voice of their own. But Kalpna was ill treated by her in-laws and was thrown out of the house. She did not inherit assets from her parents or her in-laws. She gave birth to a baby girl. She now has been compelled into prostitution in India to earn a livelihood and support herself and her daughter (Shakya 2008). She is likely to find it difficult to negotiate condom use by her clients and is hence vulnerable to AIDS.

6. GOOD PRACTICES IN BREAKING THE VICIOUS CIRCLE

Several good practices have been used to break the vicious circle between gender inequities in health, gender inequities in the economy, gender inequities in distribution of power and voice and issues of weak accountability. Some have addressed all aspects of the linkages, while others have addressed one or two aspects. The eleven examples selected here are by no means exhaustive, but illustrate the range of strategies that have been adopted in this region.

The first six follow the ‘development route’ to breaking the vicious circle, while the last five have followed the route of expanding voice and agency of women, sexual and gender minorities and men who wish to challenge dominant constructions of masculinities. In the process they have strengthened accountability of power holders for gender equity in health and the economy.

6.1 Good Practice: Model 1

Interventions targeted to all on the surface, but in fact benefiting women more than men:

The case of universal social insurance in Thailand which covers the health needs of all comprehensively.

On the surface, increases in government health expenditure on health as proportion of total government expenditure (e.g. between 2000 and 2005, Nauru saw an increase from 11 per cent to 38 per cent), increase in government health expenditure to total health expenditure (e.g. between 2000 and 2005, Afghanistan saw an increase from 1 per cent to 20 per cent) and promotion of universal social health insurance are all examples of practices that target all household members. However, these interventions benefit women more than men as women use government facilities more (WHO 2008a). Such allocation and health financing interventions will indirectly foster gender equity in the economic sphere as women would as a result have more resources to invest in their economy activity, which would have otherwise, go to out-of-pocket expenses. The case of universal social insurance is illustrated below.

- In Thailand, female-to-male earnings as of 2005 were only 62 per cent (data from UNDP 2007). Some 72 per cent of workers are employed in the informal sector, and this number is likely to include most women (ibid 2007). This implies that a majority of women have less access to cash than men and are not covered under insurance by employers. The Government of Thailand introduced universal social health insurance in 2001 to reduce the vulnerability of those in the informal sector. The social health insurance scheme provided for the establishment of a Universal Health Fund, with the support of government and local organizations, and co-payment from citizens. Poor groups may be exempted from co-payment. In early 2001, the government launched the ‘30 *baht* health policy’. Anyone who is not in any other insurance scheme and whose name is in the house registration in the provinces is insured under the 30 *baht* health policy. Each person insured receives a universal health card or ‘gold card’. Users are required to show their identification card when utilizing services. The card entitles users to pay a subsidized fee of only 30 *baht* per episode of illness, provided they use public health facilities and follow the referral system. For emergencies, however, any government health service can be accessed. From the government’s side, financing is from tax revenue. Per capita outlay is 1404 *baht* per year, part of which is paid to health care facilities according to the number of local residents registered with them. This includes costs of curative, preventive as well as promotive care. The government requires all hospitals to participate in the hospital accreditation programme to ensure that high quality care is available also to poor people. A Clinical Practice Guideline has been developed to assure the same quality of services. The 30 *baht* scheme covers all reproductive health services except obstetric services beyond the second pregnancy and infertility treatment (Ravindran 2005). However, it is not clear whether it covers treatment for sex change operations for gender minorities,

assisted reproductive technologies for lesbians or issues such as detection and treatment of cancer of testicles, penis and prostate in men. Nevertheless, improving access of women to health services would lead to greater gender equity in the economy, which in turn can improve women's participation in the economic sphere.

6.2 Good Practice: Model 2

Interventions targeted at women that address financing of women's specific health requirements: the case of maternity insurance of enterprise workers, China.

The Government of India's universal maternity cover under the National Rural Health Mission for institutional delivery in public facilities (Ministry of Health and Family Welfare 2005) and the People's Republic of China's Maternity Insurance Scheme are examples of interventions targeted at women that address the financing of women's specific health requirements. Lower out-of-pocket expenditure on maternal health care implies less indebtedness for women and their families and greater resources to invest in their economic activities later. The Chinese example is summarized below.

- In 1994 the Ministry of Labour in conjunction with the All-China Women's Federation, the All-China Federation of Trade Unions and other organizations, drafted the Proposed Methods for Maternity Insurance of Enterprise Workers, which came into effect from January 1st 1995. The Methods provided that insurance resources be publicly pooled, with enterprises surrendering maternity premiums, calculated according to a fixed percentage of worker's wages, to designated insurers to establish a maternity insurance fund. Maternity benefits consist of a maternity allowance, maternity leave with pay and health care. By presenting their maternity certificates, women workers may obtain maternity allowances from the designated insurers and have their maternity-related health care expenses reimbursed. The pay for women workers on maternity leave is fixed at the level of the enterprise's monthly average in the previous year and disbursed by the Fund. By 1997, this reform was introduced in two-thirds of China's provinces (United Nations 1997). This procedure makes it easy for women to claim maternity insurance from employers who otherwise evade paying. This scheme is likely to strengthen access of women to maternal health care; and better maternal health in the long run would also strengthen their economic participation.

6.3 Good Practice: Model 3

Interventions targeted at women that add gender and health concerns within economic programs: the case of BRAC in Bangladesh.

With the growing presence of women's micro-finance SHGs in Asia-Pacific, several governments and NGOs have attempted to add a gender and health component to micro-finance programs. One example is the case of the Mahalir Thittam (women's scheme) in the Tamil Nadu Social Welfare and Nutritious Meal Department, which has recently introduced community health insurance on a pilot basis and has sought through the SHGs to make two districts malnutrition free (Social Welfare and Nutritious Meal Department 2003). Another example is the Bangladesh Rural Academy (BRAC) which has specifically added gender and health equity component to its capacity building of group members. As the impact of BRAC is better documented it is illustrated here.

- The Bangladesh NGO, BRAC, introduced initiatives in Matlab area to promote gender and social health equity for children of poor mothers who were BRAC members in the mid 1990s. Girls were found to be disadvantaged with regard to height-for-age indicators. Three rounds of surveys were carried out in the period 1995 to 1996 at approximately four-month intervals. Stunting (height-for-age) was used as a measurement of nutritional status, and comparison was made between rates of stunting amongst children of poor BRAC members, poor non-members and non-poor non-members. The absolute rate of stunting and gender differences in stunting reduced (almost disappeared) amongst BRAC member children, while gender inequity remained large amongst non-member poor children and non-poor non-member children. That is, integrating gender and social health equity education for BRAC members helps to reduce gender inequalities in nutrition amongst children (Khatun et al. 2004). Gender equity in nutrition amongst member children may have a long-term impact on maternal health, and on women's participation in the economy. However, a study carried out in 2004 indicates that where health awareness alone (with no gender component) is added to micro-credit programs (again the case of BRAC) members, health access may improve but gender disparities may persist (Ahmed et al. 2006). That is, strengthening gender and health equity messages to members is more important than health messages alone.

6.4 Good Practice: Model 4

Interventions targeted at women that add economic equity to reproductive health programs: the case of UNFPA in Lao People's Democratic Republic.

UNFPA has been adding an economic component to their reproductive health programme in Bangladesh and Lao People's Democratic Republic. Here the Lao People's Democratic Republic intervention is described.

- In Lao People's Democratic Republic, 79 per cent of health expenditure is through private financing (in particular, out-of-pocket payments) (WHO 2008a). Hence increasing income in the hands of women is very important in the short term, and lobbying for increasing public health expenditure is important in the long term. UNFPA is collaborating with the Women's Union and Ministry of Health Fund of Lao People's Democratic Republic to set up a seed fund which will be utilized to strengthen livelihoods of women and pay for two reproductive health workers per village. In Ban Bo Piet, a village of 54 households in one of the most inaccessible mountainous areas of the country, the seed money was used by the women to combine subsistence with sustainable cash crop production (cardamom), diversify agriculture, improve women's access to markets, and use the increase in income to better access reproductive health services. Two health workers were appointed to disseminate messages on reproductive health. As a result of these interventions women are marrying later, there is a reduction in the work burden of women, the cash earnings of women have gone up, and there is greater awareness about HIV/AIDS prevention, family planning methods and the location of health services. Women's utilization of health reproductive health services has also improved (UNFPA 2002).

6.5 Good Practice: Model 5

Reducing multiple sexual, reproductive health and rights violations through one action: the policy of secondary education of girls in Bangladesh

In Bangladesh, and more recently in India, policy measures have been introduced to retain girls in school through the secondary level due to concerted advocacy by women's and girl child rights' groups. Better education of girls is likely to increase their wages once they become employed, which may in turn improve their health. Here the Bangladesh example, which has been cited as a success, is elaborated upon.

- Secondary education of girls reduces sexual rights violations of girls (especially forced and consummated marriage before 18 years of age), improves girls' understanding of their own health and reduces adolescent pregnancies which pose high risks to girls. The Government of Bangladesh launched the Female Secondary School Assistance Programme in 1994 with the aim of increasing secondary school enrolment and the retention rates of rural girls. The programme provided full scholarships covering tuition fees and all other costs, increased the numbers of female teachers, educated communities and parents about the value of girls' education, improved school infrastructure, and added occupational skills to the curriculum. By 2002, the expanded programme was supporting 5000 schools in the 118 poorest rural districts with around a million girls getting scholarships, and with almost 40 per cent female teachers. The enrolment and attendance rates for girls improved sharply and surpassed that for boys. Furthermore the proportions of married girls aged 13 to 19 years dropped significantly (Herz and Sperling 2004 cited in Sen et al. 2007).

6.6 Good Practice: Model 6

Working with men and women parents and community leaders to promote equity in infant and child survival and access to education: the case of UNICEF in Nepal

UNICEF has been working with pregnant women, husbands, parents (both fathers and mothers), and community leaders to promote access to maternal health services and gender equity in infant and child immunisation, nutrition and education. The impact of these measures on gender equity in the economy will be visible in the long run. Malnutrition in infancy and childhood continues often into adulthood and leads to a lesser ability to engage in physical work (Gillespie and Haddad 2001). An example is given from Nepal to illustrate the strategies promoted.

- In Nepal, UNICEF observed that gender inequities disadvantaging girls persisted in access to immunisation, education, malnutrition (weight-for-age and height), and that women did not have adequate access to maternal health care (UNICEF 2006b). Through its programme, Decentralised Action for Women and Children, UNICEF formed Community Action Groups comprising community leaders, pregnant women, their husbands, and parents of young children. Each group had a meeting room and a printed board which facilitated monitoring of access of pregnant women to antenatal care, anti-tetanus injections and skilled birth attendance, as well as access of male and female infants and children to immunisation, nutrition (weight-for-age), and primary education. Registration of births and contraceptive use by eligible couples were also monitored, with details on methods of contraception. Poor maternal health, access to

contraception, gender-disparities, if any, that were found in immunisation, nutrition and primary education, and lack of 100 per cent registration of births were all discussed. Those families that needed financial support were linked to UNDP's community level economic programmes in the country. Reduction in gender-disparities was observed over time. Researchers observed that fathers (and mothers') pride was hurt when their daughters (and sons too in some cases) were publicly recognised as underweight, not going to school or not being immunised, or when their wives were seen as not having access to maternal health services (Murthy and Sachdeva 2007).

6.7 Good Practice: Model 7

Advocacy to ban community practices that are harmful to women's health: the case of Hudood ordinance, Pakistan

As mentioned in the section on gender inequities in health, several harmful customary practices exist in Asia-Pacific, of which some have been legally banned in recent years; for example, women in certain parts of Nepal being obliged to deliver in cow sheds, the transfer of rape cases from Sharia to civil courts in Pakistan, the banning of female infanticide etc (Sen et al. 2007). These harmful cultural practices, where women survive, lead to stigma, depression and injuries reducing their ability to take part in economic work (in particular outside their homes. Here the advocacy of transfer of rape cases to civil courts in Pakistan is elaborated at greater length.

- According to the Human Rights Commission of Pakistan, there is a rape of a woman every two hours and a gang rape every eight hours in Pakistan. The promulgation of the *Hudood Ordinance*, 1979 under *Sharia*, which permits stoning to death of a married Muslim woman suspected of adultery and 100 lashes for an unmarried woman (and people of other faiths) suspected of having affairs has to be seen in the light of the fact that the border line between rape and adultery is thin, and whether adultery should be seen as a crime in the context of a unhappy relation is a moot question. The women's movement together with the human rights movement in Pakistan has been struggling to ban this ordinance, which is supported by extreme right-wing opinion. The efforts of rights advocates bore fruit with the passing by the National Assembly and the Upper House of the 2006 Protection of Women's Bill, which transfers the jurisdiction over rape cases from Sharia to civil courts. It also makes it easier for a woman to prove a rape allegation without being charged with adultery. Although consideration of the Bill had to be postponed earlier because of opposition from the far right, it was eventually signed into law (cited in Sen et al. 2007). While the practice of public flagging of women has not stopped in Pakistan, it has decreased since the passing of this Act. This is likely to have a bearing on the health of women, as well as increasing their mobility.

6.8 Good Practice: Model 8

Interventions targeted at men and boys to challenge violence against women: the case of Fiji women's crisis center and men against violence and abuse in India

Several women's organizations and men's networks around Asia-Pacific are working with men and boys to end violence against women. UNIFEM and UNDP have been supporting

initiatives at the country and regional level. Violence against women is a violation of their right to health and bodily integrity. It also leads to lower earnings in the market compared with women who are not subject to violence (Mallicorca-Bernable n.d.) Here an example of an initiative of a women's organization from Fiji and a men's network from India to work with men to end violence against women are illustrated.

- Fiji Women's Crisis Center, which works on the issue of gender-based violence, initiated a "Men's Program against Violence against Women", which involves training of male advocates on gender awareness, definitions and dynamics of violence against women, and exploration of men's attitudes toward women and violence. Through this programme the Crisis Center has produced television advertisements featuring men speaking out against violence, pamphlets targeted at men, and bumper-stickers condemning violence against women. The Crisis Center has conducted trainings for military and police to sensitize men on gender issues, violence against women and human rights (UNESCAP n.d.).
- In Mumbai, India, an NGO called Men against Violence and Abuse run by men has been formed with the objective of initiating changes in male attitudes on masculinities and providing a forum for men to oppose violence against women. MAVA organizes preventive programmes, public discussions on violence against women, gender sensitization programmes, as well as mass awareness programmes on violence against women using media, street plays, posters and radio. It also provides counseling and guidance to couples facing marital conflict, organizes self-defense workshops for women, and publishes a men's magazine that addresses gender issues (UNESCAP n.d.). Reduction in violence against women (apart from protecting their human rights) is likely to improve their physical and psychological health, and their participation in the economy.

6.9 Good Practice: Model 9

Working with religious leaders to change community attitudes on sexual and reproductive health: the case of UNFPA in Cambodia

NGOs like MYRADA have successfully called on Hindu religious leaders in Northern Karnataka to state in public that the practice of *devadasi system* is against the religion^{lxxxiv}. UNFPA has been working with religious leaders in Cambodia and Islamic republic of Iran to change conservative attitudes towards adolescent sexual and reproductive health. Unwanted pregnancies, unsafe abortions, Reproductive Tract Infections (RTIs) and STIs amongst adolescent girls can lower their ability to engage in paid work. Here the work of UNFPA in Cambodia with religious leaders is elaborated as an example.

- After Papua New Guinea, Cambodia has the highest rate of prevalence of HIV/AIDS in Asia-Pacific (WHO 2008a). In a survey conducted in the early 2000s, 80 per cent of adolescents believed that they could not contract HIV/AIDS. The knowledge of adolescent girls was poorer than that of adolescent boys on these issues. Monks and nuns play an important role in influencing social attitudes. There are 4000 wats or temples throughout the country, where 54,000 monks and nuns reside. There are two main Buddhist monastic orders, one for monks and another for nuns. These have played an active role in initiating medical centers in the community. UNFPA has been working since the early 1990s with the two Buddhist monastic orders to spread

messages through their sermons against trafficking and on prevention of HIV/AIDS. Along with the European Union, it is now developing strategies to disseminate messages on adolescent sexual and reproductive health through the sermons of nuns and monks (UNFPA 2004). Such measures are likely to promote the rights of adolescents to information, to reduce STIs/RTIs and in the long run contribute to the economy.

6.10 Good Practice: Model 10

Interventions aimed at strengthening the accountability of government to address women's health and young people's health: the case of Women's Health Rights advocacy partnership (WHRAP) in South Asia

The Gender and Health Equity Network, International Women's Health Coalition, the Royal Tropical Institute and Asia-Pacific Resource and Research Center on Women (ARROW) have all worked towards strengthening accountability of government health services to needs of women in different countries of Asia. Here the example of ARROW has been chosen, as it has sought to improve public maternal health services and strengthen accountability to young people's health needs. Both measures contribute indirectly to greater equity in economic spheres for women (e.g. through reduced debts and earlier entry into the work force) and adolescent girls and boys (e.g. through lesser expenses on substance use).

- The Women's Health Rights Advocacy Partnership was launched by ARROW with six partners in South Asia in 2003 (ARROW 2008). The strategy consists of building the capacity of women's community-based organizations to claim their health rights at local level, strengthening provincial and national level advocacy so as to push for health policies and implementation procedures that are more sensitive to women's and youths' health needs; and at the South Asian level to initiate regional policy dialogues between parliamentarians, health bureaucrats, women's ministries, and gender and health experts from the different South Asian countries. This strategy is now being expanded to other Asian countries.

Early impacts are already visible. In Bangladesh, because of advocacy and monitoring by Naripokko and Bangladesh Women's Health Coalition (two WHRAP partners) and the community-based women's organizations, the number of physicians in the 12 *upazilla* (sub-district) Health Advisory Committees where WHRAP is operational has increased. At the beginning of WHRAP only 2 to 4 physicians were present in each of the *upazilla* health advisory committee. There are now 7 to 8 physicians including an obstetrician/gynecologist in each *upazilla* health centre (Naripokko 2006; BWHC 2006). In Sarso, a village in Uttar Pradesh, India, where WHRAP is operational through a partner NGO Sahyog, the auxiliary nurse midwife would visit the village infrequently and often charge for services that should have been provided free. The community women asked the chief medical officer at the concerned district for a photocopy of the midwife's mandatory visiting schedule, and started monitoring her actual schedule. As a result, the concerned midwife is visiting and providing pre- and post-natal services regularly (ARROW 2006). At the national level in India, a public hearing was held on high rates of maternal mortality, which has led to a regular monitoring committee being formed.

On the issue of sexual and reproductive health for youth, in the state of Gujarat, WHRAP partner Center for Health Education Training and Nutrition Awareness (CHETNA) and other NGOs working with youth were asked to draft a Gujarat Youth Policy in keeping with the National Youth Policy. The National Youth Policy emphasizes the need to address reproductive and sexual health needs, substance use disorders, psychological problems, and nutritional needs of the young (CHETNA 2006). The policy was recently approved. This is one example of addressing masculinities and substance use disorders, which will contribute not only to the health of young but also to their ability to participate in the economy.

6.11 Good Practice: Model 11

Legal advocacy and reform to decriminalize homosexuality: the case of Nepal

As noted earlier, male homosexuality is a crime in 55 per cent of Asia-Pacific countries, and the proportion of countries where male homosexuality is a crime is higher in South and West Asian countries. Here the paper illustrates how in Nepal lesbian, gay, bisexual, transgender and inter-sexed (LGBTI) people came together to advocate for de-criminalization of homosexuality. The lesser the legal stigma attached to homosexuality the greater the ability to gain equity in the work place (although equity is not likely to follow automatically).

- In Nepal, four LGBTI organizations including the Blue Diamond Society filed a writ petition in April 2007 (05/01/2064) demanding the Supreme Court to defend and protect equal rights of LGBTI people of Nepal, after a few LGBTI activists were arrested on the grounds that homosexual activity was a criminal offence. After three hearings, in December, 2007 in a landmark judgment, the Supreme Court of Nepal recognized LGBTI people as natural persons who should enjoy all the rights of other sexes/genders enshrined by the Constitution of Nepal and by human rights conventions to which Nepal is a State Party. The Court issued directives to the government of Nepal to ensure rights to live according to their own identities, introduce laws providing equal rights to LGBTI people and amend all laws that discriminate against LGBTI people. The Court ordered the formation of a committee comprising officials from health, law and other ministries, police, and the National Human Rights Commission to address issues faced by sexual minorities and study laws in other countries on same-sex marriages (Sarkar 2007; Pant 2008). Based on the recommendations of this committee, in November 2008, the Supreme Court gave its consent to same-sex marriages and asked the government to pass legislation to this effect (Narayanan 2008).

7. DISCUSSION ON GENDER (IN) EQUITY IN HEALTH AND ECONOMY IN ASIA-PACIFIC

The paper described major gender inequities in health in the Asia-Pacific region that have a bearing on the lives of women, men and gender/sexual minorities and to examine how gender equities in the economy have a bearing on gender inequities in health and vice versa. It also analyzed how the lack of power and voice of the above groups and poor accountability of power holders has a bearing on gender inequity in health and the economy, and documented good practices on breaking the vicious links between gender inequities in health and the economy, and issues of inadequate power, voice and accountability. On the basis of this

analysis the paper has presented policy messages to foster gender equity in health and economy. Although the paper sought to document the spiraling positive effect of gender equity in health on the economy and vice versa, there is a scarcity of literature on this topic, and an attempt has been made to document some of the important good practices.

Gender inequities in health exist in some form in almost all the 42 Asia-Pacific Countries. In the majority of Asia-Pacific countries the female biological health advantage at birth is eroded progressively, with this erosion more marked in South and West Asia than Southeast and East Asia. Sex/gender-specific health needs of women, men and sexual/gender minorities are not adequately addressed by public health services in developing Asia-Pacific countries, which constitute the majority, other than routine delivery care and contraceptive services (except for the Philippines). Controversial health services, such as safe abortion services for women and genital reassignment surgery for transgender, as well as expensive services such as breast or prostate cancer treatment are not easily available in the public domain in the majority of developing Asia-Pacific countries. There is evidence that the sexual and reproductive rights of women, girls, marginalized men and boys, and sexual/gender minorities are violated in all the countries, including the industrialized ones -- though the extent and forms vary. In most Asia-Pacific countries men and boys suffer from diseases and health conditions associated with high-risk behavior, including tuberculosis, HIV, intentionally inflicted and unintentional injuries. But gender norms are changing, and the male-female gap is reducing at least with regard to high-risk behavior such as tobacco use. While cases of gender inequities in health disadvantaging men can be found in Asia-Pacific, overall, women and sexual/gender minorities are more disadvantaged, in particular those who occupy marginal positions in terms of class, caste, ethnicity, religion, abilities, location etc. Gender inequities in health are higher in South and West Asia when compared to East Asia and the Pacific. In all Asia-Pacific sub-regions, groups marginalized economically, socially and politically amongst women, men and sexual/gender minorities fare worse. *While in absolute terms, IMR, under five mortality and life expectancy are worse in Sub-Saharan Africa (but not the proportion of under-five children who are underweight) than any of the Asia-Pacific sub-regions, gender inequities in these are not reported in Sub-Saharan Africa and neither are there reports of skewed sex-ratio at birth (UNDP 2007; World Economic Forum 2008). But DALYs lost by females due to HIV are higher than males in Sub-Saharan Africa and early marriage of girls and polygamy are more common.* (Larson et al. 2006). *Disheartening is the fact that levels of under-five malnutrition and gender inequities are higher in South Asia than Sub-Saharan Africa, though overall income poverty levels are higher in Sub-Saharan Africa (World Bank n.d.).*

Gender inequities in the economy in Asia-Pacific have a close bearing on gender inequities in health. This paper confirms the findings of existing research that the gender division of labor has a close bearing on gender-differentiated health exposures and risks of women and men. The paper also reiterates findings on the links between intra-household inequalities in the allocation of food, health care and education and gender inequities in health disadvantaging women and girls. Such inequities are not only found in South Asia as much of past literature has observed, but also parts of the Pacific and the Philippines (food allocation). Anecdotal evidence suggests that parents of children who exhibit sexual/gender orientation different from that commonly associated with their sex at birth are at times forced to leave the home -- thereby denying them access to food, health care and education. This is an aspect on which not much quantitative data is available. The findings of this paper suggest that where male preference in inheritance prevails (traditionally, may be kept down now under communist rule) or where female earnings as a proportion of male earnings are low, gender inequities

disadvantaging girls and women in sex-ratio at birth, and in infant, child and adult mortality may be higher. This includes countries including China, Republic of Korea, Viet Nam, Malaysia and Singapore in East Asia; Tonga and Solomon Islands in the Pacific; and India, Nepal, Bangladesh, and Maldives in South Asia. As reliable cross-country data is not available on land ownership and inheritance patterns for all countries to support firm conclusions, further investigation is called for. Studies from India also show the links between low levels of property ownership and high levels domestic violence. But greater economic activity and lower disparities in earnings may not on their own improve maternal health. Much depends on the level of and control over earnings, whether they are in the formal or informal sector, terms and conditions of work and the division of reproductive work. For example, Papua New Guinea and Cambodia record a female-to-male economic participation ratio of over 70 per cent in 2005 but also maternal mortality ratios of 400 per 100,000 births. Another issue is the sensitivity of labour policies to specific health care needs of women, men and sexual/gender minorities. In a majority of developing countries women and men are more often employed in the informal sector than in the formal sector, and the proportion of women is slightly greater than that of men workers. Government welfare policies for workers in the informal sector provide inadequate health security. Further, at best they may provide maternal health benefits, but not benefits to cover other sex-specific health conditions of women, nor of men and sexual/gender minorities. Lastly, the work place itself is a site of sexual and reproductive rights violations against women, sexual/gender minorities and men and boys from marginalized backgrounds. *While many of these gender inequities in the economy are found in Sub-Saharan Africa as well there are two differences: women have access (not necessarily ownership) to their independent plots of land for growing and managing food crops (a greater proportion of women workers are in agriculture) and their economic participation and earnings as a proportion of those of men are higher than Asia-Pacific and particularly South Asian averages. Sex ratios at birth are not skewed and gender differentials in child malnutrition, IMR, and under-five mortality are not noted in this region. At the same time, maternal mortality ratios are also higher in Sub-Saharan Africa than Asia-Pacific and particularly South Asia*

Gender inequities in health have a bearing on gender inequity in the economy. While there have been studies on how poor health and lower incomes are related, this paper points to sex/gender-specific linkages between the two. The greater burden of diseases amongst females in Asia-Pacific due to maternal conditions (including abortions), dengue, meningitis, nutritional deficiencies, trachoma, sexually transmitted diseases (other than HIV), sense organ disorders, and musculoskeletal diseases may result in greater loss of earnings of women due to these conditions. At the same time, the greater burden of diseases amongst males due to tuberculosis, HIV/AIDS, Hepatitis C, digestive disorders, leprosy, genitourinary diseases, unintentional and intentional injuries may lead to greater loss of earnings of men due to these conditions. Overall, the burden of diseases is higher amongst females than males in the age group 15-29 years in South Asia (but not in East Asia and the Pacific), pointing to long-term impacts on their earnings and ability to move up the ladder in the economy. However, concepts such as DALYs do not capture the loss of access to household and community support systems for women with stigmatized health conditions who may be forced to leave the marital home in parts of South Asia, losing crucial economic resources, particularly with patrilineal inheritance. Women who experience widowhood because of the death of husbands due to stigmatized health conditions are at times denied rights to the husband's property and blamed for the disease. Another way in which gender inequities in health has a bearing on gender inequities in the economy is the case of certain sex-specific health services (a form of gender inequity in health) which are not available in public health

services; the costs incurred in private services are considerable for poor women, men and sexual/gender minorities. Such costs cut into long-term economic investments that women, men, sexual/gender minorities may plan for. Further, greater spending by men than women on substance use (at times taking away part of the earnings of their partners) may erode their economic resources as well as those of their partners. *A major difference between Asia-Pacific and Sub-Saharan Africa in the impact of gender inequity in health on the economy, is the greater economic costs to women of early marriage and of living with HIV in Sub-Saharan Africa (Keyvan 2006).*

Three deeper underlying factors underpin gender inequities in health and the economy disadvantaging girls/women, marginalized men and sexual/gender minorities in Asia-Pacific. First, power within the family, traditional community institutions, trade unions, companies, local government, state assemblies and parliament is held mainly by heterosexual men (and, other than in families, by men from powerful economic and social backgrounds). The patriarchal ideology perpetuated by these institutions is internalized by women and men and practices such as dowry and son preference are perpetuated in some countries (South Asia, as well as some countries in other sub-regions). Second, few Asia-Pacific countries have enacted legislation on the right of people to participate in the formulation of public policies, legislation and budgets -- which would give women, men and sexual/gender minorities a voice. While women have been organized into micro-finance self-help groups in several developing Asia-Pacific countries, these collective forums do not significantly challenge power relations and gender norms which women have internalized as much as men. Organizations of marginalized men (other than trade unions in the formal sector) are much weaker, and it is only recently that sexual/gender minorities have begun to organize. As a result, the voice of women, marginalized men and sexual gender/minorities demanding equity in health and the economy is weak. Third, there are few mechanisms for holding to account power holders in state, markets, communities and families to address gender inequities in health and the economy. The optional protocol on ICESCR has yet to be opened to governments for ratification, and not all countries in Asia-Pacific have signed the optional protocols to CEDAW and ICCPR. National Women's Commissions have less power than Human Rights Commissions. Measures for holding informal markets to account for gender equity in health and the economy are few, and formal markets are only slightly better. Measures to hold community institutions and household heads to account to follow gender-equitable economic and health practices are even fewer. Not all countries consider marital rape as rape, and intra-household inequalities in food and health care distribution are ignored. *If one compares power, voice, agency and accountability in Sub-Saharan Africa with Asia-Pacific there is one major difference: unlike the practice of dowry which is common in several South Asian countries (and a few in other sub-regions) bride price is the norm in Sub-Saharan Africa. Married women in Sub-Saharan Africa have a greater say in health decision making within the household than in South Asia, but less than in East Asia and the Pacific (UNIFEM 2008).* Women in Sub-Saharan Africa have greater mobility than in South Asia. Bride price, rather than dowry is the norm in Sub-Saharan Africa, unlike parts of South Asia. When it comes to political leadership, women occupy a slightly greater proportion of seats in parliament in Sub-Saharan Africa compared with Asia-Pacific, but are still a minority. Ratification of the optional protocol on CEDAW and legislation on marital rape is weak in Sub-Saharan Africa as well

These deeper underlying factors do not have a unidirectional linear relationship with gender inequity in health or gender inequity in the economy, but they form vicious circles which are difficult but not impossible to break. When controversial sex-specific health needs of women,

marginalized men, and sexual/gender minorities are not provided in public health services (due to inadequate power, voice and accountability) this increases costs and reduces incomes of these groups, which in turn leads to less access to health care for future morbidities. This in turn may reduce participation and earnings. Lack of access to paid sick leave in the informal sector (due to lack of power, voice and accountability) leads to lower earnings and poor access to health care services in turn. Higher proportions of women and gender minorities than men are engaged in the informal sector. Son preference – reflecting lack of power of women in societal institutions -- leads to higher female-to-male IMR and under-five mortality rates in some countries, which in turn may lead to repeated pregnancies and lower the health of women, as well as their earnings in the labour market, which again increases gender inequities in health care.

There are, however, strategies to break this vicious circle between lack of power, voice and weak accountability, and gender inequities in health. Some organizations have sought to add a component of economic empowerment of women to strategies to address gender inequities disadvantaging girls in health. Others have added gender and health equity strategies to those which seek to promote economic equity amongst women. A few governments have sought to promote universal social insurance schemes covering several (but not all) gender/sex-specific health conditions of women and men (but not sexual/gender minorities). Some donors and NGOs have sensitized religious leaders and men heads of households on gender-based violence against women, as well as health needs of adolescents. Through a more activist mode, rights-based NGOs have challenged discrimination in laws against sexual/gender minorities (Nepal) and the *Huddood* ordinance (in Pakistan). Others have mobilized women for implementation of sound gender equitable health and economic policies. Last but not the least, there have been attempts to expand girls' education, which simultaneously benefits their health and potential earnings.

At the same time there are several gaps in strategies to address the links between gender inequities in health and the economy. Few civil society actors have used human rights treaties or constitutional guarantees/directive principles to push for the right to participation, to health, to livelihood, and to gender equity -- all prerequisites for gender equity in health and the economy to be achieved. Few examples exist of holding to account leaders of community, market organizations and household heads (mainly men) on gender inequity in health and the economy. While there are examples of citizens engaging with government, strategies to make government provide controversial and low-priority health service needs of women or to address specific health needs of men and sexual/gender minorities have been less successful, and even data on these areas is far too limited. Ultimately, legal equity (for women, marginalized men and sexual/gender minorities) in general and political equity (so that they gain positions of power and decision making in social institutions) are vital.

8. RECOMMENDATIONS TO PROMOTE GENDER EQUITY IN HEALTH AND THE ECONOMY

To replicate good practices in addressing gender inequities in health and the economy and in addressing gaps in bridging these inequities and underlying issues of inadequate power, voice and agency the following recommendations are suggested:

- *Make human rights instruments work for gender equity in health and the economy in the region:* The countries that have yet to ratify ICESCR, CEDAW and optional protocol of

CEDAW should be encouraged to do so at the earliest. UN agencies, donors and NGOs should national legislation and policies for conformity with these treaties (<http://www2.ohchr.org/english/bodies/ratification/3.htm>). An Asia-Pacific Human Rights Court along the lines of Inter-American Human Rights Court should be established in the region for those whose rights have been violated under these treaties to secure redress when governments fail to respect, protect or fulfill rights.

- *Strengthen legal accountability of government for gender equity and rights to participation, health and livelihood:* All Asia-Pacific governments should be encouraged to pass legislation on the right to participation, health, gender equity and livelihoods. This will make it easier for women's rights groups and groups working for rights of sexual/gender minorities and marginalized men to demand that economic, health and gender rights be extended to them as well.
- *Strengthen powers, autonomy and capacities of women's commissions and national human rights commissions at the country level:* Governments of Asia-Pacific countries should be encouraged to strengthen the powers of national commissions on women, so that they have judicial powers and are autonomous of ruling political parties. Their capacities to take up cases of violations of women's rights and pass gender aware judgments should also be strengthened. National human rights commissions should be encouraged to investigate cases of health and economic violations against sexual and gender minorities, and of sex-specific health rights of men.
- *Increase government allocations to health (including sexual and reproductive health) and increase public expenditure as a proportion of total health expenditure.* Universal social health insurance along the model of Thailand should be promoted in other developing countries of the region. Bilateral donors for their part need to fulfill their commitments to health made at ICPD 1994 and the Millennium Summit.
- *Government and donors should move beyond cost-effectiveness and adopt a rights-based perspective in health priority setting:* The essential service package to be provided free by governments, and funded by donors in some cases, should be based on the principle of rights of all to health (including sexual and reproductive health), rather than principles of cost-effectiveness, which has left out several controversial health services needed by women, men and sexual gender/minorities (e.g. safe abortion other than for sex selection, treatment for ill health due to gender-based violence, sex reassignment surgery) and services low on the priority list of governments which are nevertheless important (e.g. sex-specific cancer treatment). More attention on the part of governments and donors to health needs of men and male homosexuals beyond HIV/AIDS is required, including vulnerability to traffic accidents, tobacco use, substance use, and high alcohol abuse.
- *Government and multi-lateral agencies should evolve additional indicators to monitor gender equity in health, economy and distribution of power/voice/accountability* for example, the proportion of land and housing owned by women, the proportion of women reporting domestic and public violence, access of men to prostate cancer screening, legalization of abortion and homosexuality, intra-household decision making power of women and men on health, the proportion of women in local self-governance etc. Specifically, data are needed on all the 46 indicators mentioned in this report on which cross country data is not available.

- *Engender public health and public administration systems, and promote multi-sectoral research.* Measures to engender public health systems would include increasing government allocation for engendering health research and clinical trials free from gender bias, creating gender-sensitive medical and health education and strengthening the position of women health workers. Measures to engender public administrative systems would include engendering national budgets, engendering national statistics, training civil servants on gender equity, and promoting action research to promote greater gender equity. Further, officials involved in public health and administration should be better informed of the relationship between gender [in] equity in health and gender equity in the economy. Positive examples of the mutually beneficial impact of gender equity in both sectors need better research and documentation.
- *Strengthen accountability of the private sector in health and the economy for gender equity in health and the economy.* This could be achieved through better regulation of the private sector by government, making it compulsory for the private sector to abide by legislation pertaining to health, social security, employment and gender equity, and giving tax incentives to those companies that promote gender equity for the poor in health and the economy.
- *Improve economic, social and health security of those in the informal sector* which will benefit all the poor, and women and sexual/gender minorities more than men, since they are engaged in the informal sector more than men. Implementation of employment guarantee schemes with equal wages, access to small and medium-scale credit (presently cornered by men), safe markets with gender-segregated toilets, health and accident insurance for workers and pension schemes for those in the informal sector – could all help strengthen gender and health equity in the long run.
- *Integrate gender and health with economic interventions targeted at women and sexual/gender minorities:* As attempted by BRAC in South Asia, health insurance, gender and health awareness and awareness of health entitlements may be added to economic programs targeted at women. There is a great potential for doing this given the scale of women's micro-finance self-help groups in the region.
- *Integrate economic empowerment into health interventions targeted at women and sexual/gender minorities.* This could take the form of special economic interventions with women in households where rates of anemia are high amongst females and where domestic violence persists, with single women and their daughters who are vulnerable of trafficking, and with sexual/gender minorities who are vulnerable to exploitation.
- *Initiate interventions through NGOs targeted at men and boys in households and communities* (community leaders and religious leaders) that challenge dominant norms on masculinities (including on dowry, violent behavior and substance use) that harm their health and that of women; as well as lead to gender inequities in the economy, and address their sex-specific health needs.
- *Support programmes to strengthen voice and informed agency of women, sexual/gender minorities and men who challenge dominant masculinities* at local, district, provincial, national, sub-regional and regional levels. The model adopted by ARROW and its partners through WHRAP could be broadened and extended to other countries and to

include sexual/gender minorities and men who challenge dominant masculinities. The organizations representing the above groups should hold the government, donors and markets accountable from below for implementing international and enlarged national laws and policy commitments.

Overall, equity in two important spheres is important for the achievement of gender equity in health and the economy: gender and legal equity and gender and political equity. Legal equity refers both to formal laws that are enacted in Parliament and to informal customary laws that are determined by community norms and leaders. Political equity does not mean equity in participation and decision making only in formal political processes, but also in informal ones -- at the household, community and economic organization level. An overarching recommendation is that gender equity at these two levels is promoted by governments, donors and civil society actors.

Technical note 1

Definition of Indicators

Adolescent Fertility Rate: The age-specific fertility rate for females ages 15-19, which is expressed as the annual number of births per 1,000 women aged 15-19 (WHO 2006b).

Adult mortality: (probability of dying between 15 to 60 years per 1000 population)
Probability that a 15-year-old person will die before reaching his/her 60th birthday (WHO 2006b).

Antenatal care coverage (percentage) Percentage of women who utilized antenatal care provided by skilled health personnel for reasons related to pregnancy at least once during pregnancy as a percentage of live births in a given time period (WHO 2006b).

Births attended by skilled health personnel (percentage): Percentage of live births attended by personnel skilled and suitably equipped in a given period of time A **skilled birth attendant** is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (WHO 2006b).

Condom use by young people at higher risk aged 15-24 years (Percentage): Percentage of young people aged 15-24 years reporting the use of a condom during the last sexual intercourse with a non-regular partner among those who had sex with a non-regular partner in the last 12 months (WHO 2006b).

Contraceptive prevalence rate: is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given time (WHO 2006b).

The Disability Adjusted Life Year or DALY: is a health gap measure that extends the concept of potential years of life lost due to premature death to include equivalent years of 'healthy' life lost by virtue of being in states of poor health or disability. DALYs for a disease or health condition are calculated as the sum of the years of life lost due to premature mortality in the population and the years lost due to disability for incident cases of the health condition (WHO 2006b).

Dependent Population (% of total population): As used in this report indicates percentage of population under age 15 and percentage of population age 65 and above as a percentage of total population. This has been calculated from data in Human Development Report 2007 (UNDP 2007).

General government expenditure: includes consolidated direct outlays and indirect outlays (e.g. subsidies to producers, transfers to households), including capital of all levels of government, social security institutions, autonomous bodies, and other extra-budgetary funds (WHO 2006b).

General government expenditure on health: comprises the direct outlays earmarked for the enhancement of the health status of the population and/or the distribution of medical care goods and services among population by the following financing agents: central/federal,

state/provincial/regional, and local/municipal authorities; extra-budgetary agencies, social security schemes; para-statal. All can be financed through domestic funds or through external resources (WHO 2006b).

Enrolment ratio, gross combined, for primary, secondary and tertiary schools: The number of students enrolled in primary, secondary and tertiary levels of education, regardless of age, as a percentage of the population of official school age for the three levels (UNDP 2007).

Employment by economic activity: Employment in industry, agriculture or services as defined according to the International Standard Industrial Classification system. *Industry* refers to mining and quarrying, manufacturing, construction and public utilities. *Agriculture* refers to activities in agriculture, hunting, forestry and fishing. *Services* refer to wholesale and retail trade; restaurants and hotels; transport, storage and communications; finance, insurance, real estate and business services; and community, social and personal services, (UNDP 2007).

Female and male labor force participation rate: Refers to the number of women/men in the labor force expressed as a percentage of the female/male working-age population (UNDP 2007).

Female professional and technical workers (percentage): Women's share of positions defined according to the International Standard Classification of Occupations (ISCO-88) to include physical, mathematical and engineering science professionals (and associate professionals), life science and health professionals (and associate professionals), teaching professionals (and associate professionals) and other professionals and associate professionals (UNDP 2007).

Female legislators, senior officials and managers (percentage): Women's share of positions defined according to ISCO-88 to include legislators, senior government officials, traditional chiefs and heads of villages, senior officials of special-interest organizations, corporate managers, directors and chief executives, production and operations department managers and other department and general managers (UNDP 2007).

Healthy life expectancy: Average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury (WHO 2006b).

Infant Mortality Rate (per 1000 live births): The probability of a child born in a specific year or period dying before reaching the age of one, if subject to age-specific mortality rates of that period (WHO 2006b).

Human development index (HDI): A composite index measuring average achievement in three basic dimensions of human development: a long and healthy life (measured in terms of life expectancy at birth), knowledge (adult literacy rate and gross enrolment ratio) and a decent standard of living (Gross domestic product per capita, PPP US\$) (UNDP 2007).

Human poverty index for developing countries: A composite index measuring deprivations in the three basic dimensions captured in the human development index, a long and healthy life (probability at birth of not surviving age 40), knowledge (adult literacy rate) and a decent standard of living (percentage of population not using improved water source

and percentage of children underweight for age) (UNDP 2007).

Lifetime risk of maternal mortality: the probability that a 15 year old female will die eventually from a maternal cause (UNIFEM 2008).

Ratio of estimated female to male earned income: The ratio of estimated female earned income to estimated male earned income. Estimation is derived on the basis of the ratio of the female nonagricultural wage to the male nonagricultural wage, the female and male shares of the economically active population, total female and male population and GDP per capita (in purchasing power parity terms in US dollars) (UNDP 2007).

HIV prevalence rate: Percent of people with HIV infection among all people aged 15-49 years (WHO 2006b).

Population below the income poverty line: The percentage of the population living below the specified poverty line (UNDP 2007).

Informal sector employment as a percentage of nonagricultural employment: Refers to the ratio of total employment in the informal sector to total employment in all nonagricultural sectors (UNDP 2007).

Maternal mortality ratio (per 100 000 live births): Number of maternal deaths per 100 000 live births during a specified time period, usually one year (WHO 2006b).

Newborns with low birth weight (%): Percentage of live born infants with birth weight less than 2,500 gm in a given time period. Low birth weight may be subdivided into very low birth weight (less than 1500 g) and extremely low birth weight (less than 1 000 g) (WHO 2006b).

Population below income poverty line: Refers to percentage of population living below the specified poverty line (UNDP 2007).

Prevalence of adults (15 years and older) who are obese (percentage): Percentage of adults classified as obese (BMI = 30.0 kg/m²) among total adult population (15 years and older) (WHO 2006b).

Population with sustainable access to an improved water source (percentage) is the percentage of population with access to an improved drinking water source in a given year. Improved water sources include household connections, public standpipes, boreholes, protected dug wells, protected springs, and rainwater collections (WHO 2006b).

Population with access to improved sanitation (percentage): Is the percentage of population with access to improved sanitation in a given year. Improved sanitation includes connection to a public sewers, connection to septic systems, pour-flush latrines, simple pit latrines and ventilated improved pit latrines. Not considered as improved sanitation are service or bucket latrines (where excreta is manually removed), public latrines and open latrines (WHO 2006b).

Prevalence of current tobacco use in adolescents (13-15 years of age): Prevalence of tobacco use (including smoking, oral tobacco and snuff) on more than one occasion in the 30

days preceding the survey, among adolescent 13-15 year olds, (WHO 2006b).

Prevalence of current tobacco smoking among adults (15 years and older) (percentage):

Prevalence of current tobacco smoking refers to smoking cigarettes, cigars, pipes or any other smoked tobacco products both daily and non-daily or occasional smoking (WHO 2006b).

Private health expenditure: Is defined as the sum of expenditures on health by the following entities, private prepaid plans and risk-pooling arrangements, firms' expenditure on health, Non-profit institutions serving mainly households, and Household out-of-pocket spending (WHO 2006b).

Sex ratio at birth is the ratio between male births and female births (or vice versa) of an observed population. In this paper, the ratio of female to male births has been used (World Economic Forum, 2008).

Seats in parliament held by women: Refers to seats held by women in a lower or single house or an upper house or senate, where relevant (UNDP 2007).

Total expenditure on health: Is the sum of general government health expenditure and private health expenditure in a given year, calculated in national currency units in current prices (WHO 2006b).

Total Fertility rate: Refers to the number of children that would be born to each woman if she were to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates in a given year/period, for a given country, territory or geographical area (UNFPA 2007).

Under-5 Mortality Rate (Probability of dying by age 5 per 1000 live births: Refers to the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period (WHO 2006b).

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END NOTES

ⁱ <http://www.thefreedictionary.com/economy>, last accessed January 15th, 2008.

ⁱⁱ Access to resources refers to ability to use resources, ownership refers to legal or customary ownership, while control refers to ability to make decisions related to resources (Murthy and Oxfam GB 2007)

ⁱⁱⁱ It is not clear whether the reference to societies by Blumberg implies countries or specific communities within countries (Blumberg 2005).

^{iv} The two countries on which no data on population was available from the Human Development Report 2007/2008 were Cook Islands and Niue (UNDP 2007).

^v The 10 countries on which no data on spatial distribution of population was available from the Human Development 2007/2008 includes Democratic People's Republic of Korea, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu and Afghanistan (UNDP 2007).

^{vi} The 10 countries on which no data on proportion of dependent population could be computed from the HDR 2007/2008 were Democratic People's Republic of Korea, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu and Afghanistan (UNDP 2007).

^{vii} The 10 countries on which no data on Human Development Index was available from the HDR 2007/2008 include Democratic People's Republic of Korea, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu and Afghanistan (UNDP 2007).

^{viii} Of the 32 countries on which data on HDI was available from the HDR 2007/2008, Hong Kong, China (SAR), Japan, Republic of Korea, Brunei Darussalam, Malaysia, Singapore, Australia, New Zealand and Tonga are high human development countries (UNDP 2007).

^{ix} The 18 countries for which no information on proportion in human poverty was available from the HDR 2007/2008 were Hong Kong, China (SAR), Japan, Democratic People's Republic of Korea, Republic of Korea, Australia, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, New Zealand, Niue, Palau, Brunei Darussalam, Samoa, Tonga, Tuvalu, and Afghanistan (UNDP 2007).

^x The 15 countries for which data on proportion of population below income poverty of US\$1 and US\$2 was available from the HDR 2007/2008 include Cambodia, China, Republic of Korea, Lao People's Democratic Republic, Mongolia, Indonesia, Malaysia, Philippines, Thailand, Bangladesh, India, Islamic Republic of Iran, Nepal, Pakistan and Sri Lanka (UNDP 2007).

^{xi} The average excludes those countries for which the figures were not specific like <2 per cent living below income poverty line of US\$1 or US\$2 a day. See the example of Republic of Korea (UNDP 2007).

^{xii} The 9 countries on which no data on total population with access to improved drinking water from the World Health Statistics, 2008 was available include Hong Kong, China (SAR), Republic of Korea, Brunei Darussalam, Singapore, Marshall Islands, Nauru, New Zealand, Vanuatu, and Islamic Republic of Iran (WHO 2008a).

^{xiii} The 10 countries on which no data on total population with access to improved sanitation was available from the World Health Statistics include Hong Kong, China (SAR), Democratic People's Republic of Korea, Republic of Korea, Brunei Darussalam, Singapore, Marshall Islands, Nauru, New Zealand, Vanuatu and Islamic Republic of Iran (WHO 2008a).

^{xiv} Schistosomiasis (also known as bilharzia, bilharziosis or snail fever) is a parasitic disease caused by several species of fluke of the genus *Schistosoma*. Although it has a low mortality rate, schistosomiasis often is a chronic illness that can damage internal organs and, in children, impair growth and cognitive development. The urinary form of schistosomiasis is associated with increased risks for bladder cancer in adults.^[1] Schistosomiasis is the second most socioeconomically devastating parasitic disease after malaria.

[<http://en.wikipedia.org/wiki/Schistosomiasis>]

^{xv} Elaborated in Section 4.1.1.

^{xvi} Though women may also be suffering from sexual dysfunction this has been much less researched.

^{xvii} The Global Gender Gap report has arrived at the female to male ratio of Health Life Expectancy Ratio of 1.06 by using the computations used by UNDP for calculating the Gender Development Index, which used a maximum of 87.5 years for females and 82.5 years for males (World Economic Forum 2008, see page 24).

^{xviii} The greater vulnerability of females than males to contract STIs from infected partners is due to the greater surface area of mucous membrane exposed during sexual intercourse, greater infectiveness of semen, greater exposure to a larger quantity of infected fluid (WHO 2003b; Sen et al. 2008).

^{xix} The lone territory on which no data on Infant Mortality Rate was available from the World Health Statistics 2008 was Hong Kong, China (SAR) (WHO 2008a).

^{xx} The lone territory on which no data on Under-five Mortality Rate was available from the World Health Statistics 2008 was Hong Kong, China (SAR) (WHO 2008a).

^{xxi} There was no data on Healthy Life Expectancy at Birth (2002) for Hong Kong, China (SAR), or gender differentials therein, in the World Health Statistics 2008 (WHO 2008a).

^{xxii} There was no data on Adult Mortality Rate (2006) for Hong Kong, China (SAR) in the World Health Statistics 2008 (WHO 2008a).

^{xxiii} The issue of how gender and sex interact to lead to greater obesity is not included in the main text, as it affects a small section of the population as of now. Sex differences (fat collects more easily on adult females than males) and gender norms (restrictions on women's mobility, women's time to exercise, and work force participation) together lead to higher obesity amongst adult females than males in all of the 16 countries on which data was available from the World Health Statistics 2008. The countries include China, Japan, Lao People's Democratic Republic, Mongolia, Indonesia, Malaysia, Singapore, Cook Islands, Fiji, Nauru, New Zealand, Samoa, Tonga, Vanuatu, India and Islamic Republic of Iran (WHO 2008a).

^{xxiv} The ICPD+5 sets a target of improved access to antenatal care and 80 per cent access to skilled birth attendance by 2005. The same target as for skilled birth attendance has been assumed for ante-natal care coverage in this paper (UNFPA year?) [unfpa.org/icpd/icpd5-keyactions.cfm] Last accessed 5th February 2009.

^{xxv} Data on access to ANC (2000-2006) was available for Cambodia, Democratic People's Republic of Korea, Viet Nam, Indonesia, Myanmar, Philippines, Thailand, Timor-Leste, Bangladesh, India, Maldives, Nepal from World Health Statistics 2008 (WHO 2008a).

^{xxvi} ICPD+5 target for births attended by skilled birth attendance to be achieved by 2005 [unfpa.org/icpd/icpd5-keyactions.cfm]. Last accessed on 5 February, 2009. (UNFPA year?)

^{xxvii} There was no data on births attended by skilled health personnel (2000-2006) for Hong Kong, China (SAR) in the World Health Statistics 2008 (WHO 2008a).

^{xxviii} Elaboration based on WHO (2008) by UNIFEM in Progress of the World's Women 2008/2009 (UNIFEM 2008).

^{xxix} Proportion of births attended by skilled health personnel stood at 100 per cent as of 2000-2006 in Singapore, Japan, Republic of Korea, Malaysia, Australia, Cook Islands, Tuvalu, Nauru, Brunei Darussalam, Niue, Palau and Samoa as per the World Health Statistics 2008 (WHO 2008a).

^{xxx} The countries on which information on economic and spatial inequalities in access to skilled birth attendance was available from the World Health Statistics include Cambodia, Viet Nam, Indonesia, Philippines, Bangladesh, India, Nepal and Pakistan (WHO 2008a).

^{xxxi} Global average on proportion of low birthweight newborns was secured from World Health Statistics 2008 (WHO 2008a).

^{xxxii} There was no data on Low birth weight newborns (2000-2006) for Hong Kong, China (SAR), Nauru, Niue, Tonga, Afghanistan in the World Health Statistics 2008 (WHO 2008a).

^{xxxiii} In East Asia and Pacific the main cause of maternal deaths were maternal hemorrhage, hypertension, abortion, maternal sepsis, obstructed labor and other maternal conditions. In South Asia the pattern was similar but abortion and hypertension were both the second most important known reason for maternal death (Lopez et al. 2006).

^{xxxiv} There was no data on Maternal Mortality Ratio (2005) for Hong Kong, China (SAR), Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Samoa, Tonga, Tuvalu, Vanuatu in the World Health Statistics 2008 (WHO 2008a).

^{xxxv} Data from World Development Indicator Database (World Bank n.d).

^{xxxvi} The lifetime risk of maternal death refers to the probability that a 15-45 year old female would die eventually from a maternal cause (UNIFEM 2008).

^{xxxvii} Women 21 to 29 should get a Pap every two years, then annually from ages 30 to 64 years.

^{xxxviii} <http://womenshealth.about.com/cs/cervicalcancer/a/cervcananpapsme.html> Last accessed 6th June 2011.

^{xxxviii} Pap Smear: A screening test for cervical cancer based on the examination under the microscope of cells collected from the cervix, smeared on a slide and specially stained to reveal premalignant (before cancer) and malignant (cancer) changes as well as changes due to noncancerous conditions such as inflammation from infections. When diagnosed early, cervical cancer can be treated [http://www.medterms.com/script/main/art.asp?articlekey=6329] Last accessed 13th April 2009.

^{xl} Information on proportion of women who have had pap smear was available for the period 2000-2006 for China, Japan, Lao People's Democratic Republic, Viet Nam, Malaysia, Myanmar and Philippines, Australia, New Zealand, Bangladesh, India, Nepal, Pakistan and Sri Lanka from the World Health Statistics 2008 (WHO 2008a).

^{xli} A mammogram is an x-ray image of the breast. Mammography is the procedure used to generate a mammogram [<http://brighamrad.harvard.edu/patients/education/Mammo/define.html>] Last accessed on 13 April 2009.

^{xlii} Women aged 40-49 should have annual screening mammography, Women aged 50-69 should have screening mammography at two year intervals unless they have a strong family history of breast cancer and women over the age of 70 should continue to have screening mammography if they are in good health

[<http://www.breastscreening.ns.ca/index.php/mammography-guidelines>] Last accessed July 6th 2011.

^{xliii} Information on proportion of women who have had mammography for the period 2000-2006 was available for the same countries as for pap smear from the World Health Statistics 2008 (WHO 2008a).

^{xliv} Prostate cancer is the uncontrolled growth of cells in the prostate: Early symptoms of prostate cancer include difficulty in urinating, the need to go to the bathroom frequently, a weak urine stream and a feeling that the bladder is always full. These alterations appear as a consequence of the increase in size of the prostate and the increase in its muscular portion, which presses against the urethra and hinders the elimination of the urine stored in the bladder. Prostate cancer can be treated with medication, local heat therapy, vaporization, laser and conventional surgery (Instituto Promundo 2002).

^{xlv} Sexual dysfunction is referred to situations when a man experiences certain difficulties, physical or psychological, in expressing or enjoying sexual pleasure. The dysfunctions can have organic causes (cardiovascular conditions or diseases, diabetes, side effects of medication, drug use etc.) or psychological (upbringing, anxiety, guilt, marital problems, previous frustrating or traumatic experiences, stress etc.).

^{xlvi} Erectile dysfunction when a man is unable to have an erection. It can be in two forms: primary (when the man has never had an erection) or secondary (when it appears in a man who had not had problems before). Premature ejaculation when a man ejaculates involuntarily before penetrating the vagina or immediately after the penetration and Retarded ejaculation is when a man is unable to ejaculate (Instituto Promundo 2002).

^{xlvii} The most common symptom is the appearance of a small hard nodule which does not cause pain.

^{xlviii} Symptoms of penile cancer include wounds that do not heal after medical treatment; lumps that do not disappear after treatment and which present secretion and a bad smell; redness and itching (inflammation) for long periods; whitish stains or loss of pigmentation; or the appearance of bulbous tissues in the groin. If any of them appear, it is necessary to consult a doctor immediately (Nicolosi et al. 2003).

^{xlix} The 21 countries on which information on sex-ratio at birth was available from the Global Gender Gap Report were Cambodia, China, Japan, Republic of Korea, Mongolia, Viet Nam, Brunei Darussalam, Indonesia, Malaysia, Philippines, Singapore, Thailand, Australia, New Zealand, Bangladesh, India, Islamic Republic of Iran, Maldives, Nepal, Pakistan and Sri Lanka (World Economic Forum 2008).

^l Data on Early marriage (women) was available for Cambodia, China, Hong Kong, China (SAR), Lao People's Democratic Republic, Mongolia, Viet Nam, Indonesia, Malaysia, Myanmar, Philippines, Singapore, Thailand, Fiji, Papua New Guinea, Bangladesh, Bhutan, India, Islamic Republic of Iran, Nepal, Pakistan, Sri Lanka in the Gender, Development and Institutions Database 2009 of OECD (OECD 2009).

^{li} There was no data on Adolescent fertility rate (2000-2006) for Hong Kong, China (SAR), Democratic People's Republic of Korea, Myanmar, Thailand, Timor-Leste, Cook Islands, Kiribati, Marshall Islands, Nauru, Niue, Palau, Papua New Guinea, Solomon Islands, Tuvalu, Vanuatu, Sri Lanka in the World Health Statistics 2008 (WHO 2008a).

^{lii} Data on prevalence of female genital mutilation was available for China, Japan, Republic of Korea, Viet Nam, Indonesia, Malaysia, Myanmar, Philippines, Thailand, Australia, Fiji, New Zealand, Bangladesh, India, Islamic Republic of Iran, Nepal, Pakistan and Sri Lanka from the Global Gender Gap report 2008 (World Economic Forum 2008).

^{liii} Data on legality of female homosexuality was available for all countries other than Timor-Leste, Federated States of Micronesia, Palau and Bangladesh and for male homosexuality for all countries other than Timor-Leste, Federated States of Micronesia and Palau [http://en.wikipedia.org/wiki/LGBT_rights_by_country_or_territory]. Last accessed 15 April 2009.

^{liv} There was no data on prevalence of current tobacco used by adults (2005) for Hong Kong, China (SAR), Democratic People's Republic of Korea, Brunei Darussalam, Singapore, Timor-Leste, Kiribati, Marshall Islands, Federated States of Micronesia, Solomon Islands, Niue, Papua New Guinea, Tuvalu, Afghanistan and Bhutan in the World Health Statistics 2008 (WHO 2008a).

^{lv} HIV prevalence rate was higher amongst males than females in Cambodia, Republic of Korea, Mongolia, Lao People's Democratic Republic, Viet Nam, Indonesia, Malaysia, Myanmar, Singapore, Thailand, Australia, New Zealand, Papua New Guinea, Bhutan, India, Islamic Republic of Iran and Nepal (UNFPA 2007).

^{lvi} HIV incidence' is the number of new HIV infections in the population during a certain time period [<http://www.avert.org/statistics.htm>] (Avert. n.d.).

^{lvii} The HIV prevalence rate was similar for females and males in China, Japan, Philippines, Timor-Leste, Fiji, Afghanistan, Bangladesh, Sri Lanka, Maldives and Pakistan (UNFPA 2007).

^{lviii} 'HIV prevalence' is given as a percentage of a population. If a thousand truck drivers, for example, are tested for HIV and 30 of them are found to be positive, then the results of a study might say that HIV prevalence amongst truck drivers is 3%. [<http://www.avert.org/statistics.htm>] (Avert n.d.).

^{lix} Data on social acceptance of polygamy was available for China, Japan, Republic of Korea, Viet Nam, Indonesia, Malaysia, Myanmar, Philippines, Thailand, Australia, New Zealand, Bangladesh, India, Islamic Republic of Iran, Nepal, Pakistan and Sri Lanka from the Global Gender Gap report 2008 (World Economic Forum 2008).

^{lx} There was no data on General Government expenditure on health as percentage of total expenditure on health (2005) for Hong Kong, China (SAR) in the World Health Statistics 2008 (WHO 2008a).

^{lxi} Data on out- of-pocket expenses as percentage of private expenditure on health was available for 41 countries from the World Health Statistics 2008 (WHO 2008a). The data indicates that out of pocket expenses account for 80.9 per cent of total private health expenditure for the 41 Asia-Pacific countries as a whole, being much higher than the average in South and West Asia (93.9 per cent), slightly higher than the average in East Asia (82.6 per cent) and significantly lower than the average in the case of Pacific at 71.8 per cent. Out of pocket expenditure as percentage of total private health expenditure was around the average in developing countries (80.6 per cent), and below in the case of developed countries (71 per cent) (WHO 2008a).

^{lxii} Data was not available on social security expenditure as a percentage of total government expenditure for Brunei Darussalam and Hong Kong, China (SAR) from the World Health Statistics 2008 (WHO 2008a).

^{lxiii} Data on employment in agriculture, industry and services (1995-2005) was available for Cambodia, Hong Kong, China (SAR), Japan, Republic of Korea, Lao People's Democratic Republic, Mongolia, Viet Nam, Brunei Darussalam, Indonesia, Malaysia, Philippines, Singapore, Thailand, Australia, New Zealand, Bangladesh, Islamic Republic of Iran, Maldives, Pakistan and Sri Lanka from the Human Development Report, 2007/2008 (UNDP 2007).

^{lxiv} Factors other than gender bias in households like availability of schools with toilets also have a role to play in girls' enrolment after primary levels.

^{lxv} There was no data on the ratio of female to male gross primary enrolment and (2005) for Democratic People's Republic of Korea, Singapore, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu, Afghanistan and Bhutan in the Human Development Report 2007/2008 (UNDP 2007).

^{lxvi} There was no data on the ratio of female to male gross secondary enrolment (2005) for Democratic People's Republic of Korea, Singapore, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu, Afghanistan and Bhutan in the Human Development Report 2007/2008 (UNDP 2007).

^{lxvii} There was no data on the ratio of female to male gross tertiary enrolment (2005) for Democratic People's Republic of Korea, Myanmar, Singapore, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Papua New Guinea, Solomon Islands, Tuvalu, Afghanistan, Bhutan, Sri Lanka in the Human Development Report 2007/2008 (UNDP 2007).

^{lxviii} Data on ratio of estimated female to male earned income was not available for Democratic People's Republic of Korea, Myanmar, Timor-Leste, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu, Afghanistan and Bhutan in the Human Development Report 2007/2008 (UNDP 2007).

^{lxix} No data was available on female economic activity rate as a percentage of male economic activity rate for Democratic People's Republic of Korea, Cook Islands, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu, and Afghanistan from the Human Development Report 2007/2008 (UNDP 2007).

^{lxx} As per data provided by the Global Gender Gap Report, 2008 amongst the 20 Asia-Pacific countries on which data was available in none were women's wages same as that of men of men. Women's wages was 67.5 per cent of men's wages for the 20 countries, and the comparative figure was 59 per cent in South and West Asia, 70 per cent in Pacific and 71 per cent in Pacific and was 67.8 per cent in developing countries and 66.3 per cent in developed countries. That is the levels of economic development did not make a dent on gender equity in wages (World Economic Forum 2008)

^{lxxi} Namely Nauru, Tuvalu and Federated States of Micronesia for infant and under-five mortality, and Tuvalu for adult mortality and healthy life expectancy.

^{lxxii} The countries on which information on the period of paid maternity leave was available (from the Global Gender Gap Report 2008) were Cambodia, China, Japan, Republic of Korea, Mongolia, Viet Nam, Indonesia, Malaysia, Philippines, Singapore, Thailand, New Zealand, Niue, Bangladesh, India, Islamic Republic of Iran, Nepal, Pakistan and Sri Lanka. The information provided for Australia was ambiguous as it cited 12 months of

paid maternity leave, and at the same time 0 per cent of wages paid. Data on Australia has hence been left out (World Economic Forum 2008).

^{lxxiii} The Gender Equity Index (parental leave) is based on the proportion of leave available for fathers/or reserved exclusively for fathers (nine points), percentage of earnings replaced during leave (five points), and policy incentives that encourage men to avail or not avail leave (one point) (Ray, Gornick and Schmith 2008).

^{lxxiv} The data on maternity benefits as percentage of wages was available for the same list of countries as on which information on length of paid maternity leave was available. Though there was information on maternity benefits as percentage of wages for Australia as well it was put at 0 per cent which is contradictory with the information that women were eligible for 12 months of paid maternity leave in Australia given in the same report. Hence Australia has not been taken for calculation (World Economic Forum 2008).

^{lxxv} Discussions of author with garment workers in Sri Lanka in January 2008.

^{lxxvi} Younger girls, who are majority of the survivors of acid attacks, dropped out of school.

^{lxxvii} Personal communication of the author (January 2009) with a survivor of domestic violence working in a soft ware company in Chennai, India.

^{lxxviii} The countries listed by the World Bank Group under East Asia and Pacific were American Samoa, Cambodia, China, Fiji, Indonesia, Kiribati, Democratic People's Republic of Korea, Lao People's Democratic Republic, Malaysia, Marshall Islands, Federated States of Micronesia, Mongolia, Myanmar, Marian Islands, Palau, Papua New Guinea, Samoa, Solomon Islands, Thailand, Timor-Leste, Tonga, Vanuatu. The countries listed under South Asia by the World Bank Group include Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka (Lopez et al. 2006)

^{lxxix} The 14 Asia-Pacific countries for which no data was available from the Human Development Report 2007/2008 on seats in Parliament held by women were Hong Kong, China (SAR) , Democratic People's Republic of Korea, Brunei Darussalam, Myanmar, Cook Islands, Fiji, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Tuvalu, and Afghanistan (Lopez et al. 2006).

^{lxxx} South Asia: Sri-Lanka, India, Pakistan, Nepal and Bangladesh, South East Asia: Thailand, Malaysia and the Philippines, East Asia and the Pacific: China, Viet Nam, Japan, Australia and New Zealand.

^{lxxxi} The countries for which information on proportion of women workers in unions was available from the Women of the World 2009 were Viet Nam, China, India, Bangladesh, Philippines, Japan, Republic of Korea and Singapore (UNIFEM 2008).

^{lxxxii} Information was not available on ratification status of international treaties for Hong Kong, China (SAR) [<http://www2.ohchr.org/english/bodies/ratification/3.htm>] Last accessed 20th January 2009.

^{lxxxiii} Discussion with Save the Children, Sweden Denmark and community men in Rajsahi district in Bangladesh 2006

^{lxxxiv} Personal experience of working in the organization between 1984 and 1988.