Health and well-being of women in mountain areas of the Asia Pacific region

Ritu Bhatia

Summary

This paper looks at the low status of women across the Asia Pacific region, although there are variations from one region to another. In Nepal, up to 80% of women of childbearing age are anaemic, suffering from a lack of iron, vitamin A, protein, and iodine. In Burma, mountain women have the lowest levels of income, highest illiteracy rates, and no access to basic health, education, and social services. Gender oppression occurs in the form of violence and physical abuse, extreme work and health stresses, and the culture of giving women all the responsibility of household and farm labour without giving them any rights to land or the household economy. The hardships with which women live contribute significantly to their vulnerability to disease and ill health. Violence involving sexual assault can carry the risk of human immunodeficiency virus/aquired immune deficiency syndrome (HIV) infection, unwanted pregnancies, and other sexual and reproductive health problems. In remote areas with sparse health facilities, the risks of childbearing are high for women.

Studies show that the workload of mountain women has been increasing along with environmental degradation. The backbreaking chores of carrying water, fodder, and fuelwood up and down steep mountain slopes continue. Male outmigration, as families search for ways to sustain their lives and farmlands during scarcity, worsens the situation.

In fact, women have the power to improve or devastate their environments and the impact of environmental degeneration is also felt most by them. In Vietnam, for instance, women account for 50% of the mountain people and more than 60% of the country's workforce. They also participate, either

directly or indirectly, in serious forest devastation to make way for more fields for cultivation. The loss of forest acreage has meant even harder work for women, as they are responsible for fetching firewood from the forests not only for daily cooking and fuel during winter but also for selling or bartering for food. The shortage of water and inadequate sanitation, partly caused by women, bring many diseases among mountain populations, such as skin disease, cholera, dysentery, and gynaecological diseases, not to mention the greater burden of work as women must spend more time collecting water for drinking and cooking.

Despite the recognition of the universal right to sexual and reproductive health by the International Conference on Population and Development (ICPD) Programme of Action (POA), and the reaffirmation of that at subsequent international forums, the woman's role in the family remains rigid in much of Asia. The man is considered the head of the family and controls sexuality and reproduction. Thus, pregnancy and childbirth is often forced on young married women too quickly and too often. This is shown by the average total fertility rate (TFR) in some countries: The TFR in Nepal, for example, is 4.6 children, although the desired family size is 2.9 children.

The Cairo POA declared education as an important means of empowering women. Educated women marry later, want fewer children, are more likely to adopt effective methods of contraception, and understand the overall importance of their reproductive rights. The disparity between boys and girls in receiving education, however, slows the spread of awareness. The ultimate preference for sons over daughters results in an education gender gap, evident most notably in Pakistan, where the gender gap score (based on an average of primary and secondary enrolment rates) is 36%. Further, given the lack of sex education, women do not have the knowledge to make decisions regarding their own reproductive and sexual lives. One alarming consequence is the widespread growth of HIV/AIDS, estimated by the World Health Organisation (WHO) to be spreading faster in Asia than in any other part of the world.

It is the lack of services that most detrimentally affects women's health and reproductive rights because of the lack of easy access to modern medical centres, the absence of such facilities in nearby locations, or the physical barrier posed by the country's rugged terrain and the lack of adequate transportation facilities. In the urban areas of Nepal, 81% of the people have access to health service facilities with doctors, while only 47.3% of the rural people have such access. Although the government has made important strides in expanding its network of health facilities, health coverage, and specifically reproductive health (RH) services, are inadequate.

In China, the poorer northwest and southwest provinces show higher mortality rates because people lack or have limited access to health services: the

maternal mortality rate in rural areas is 76 per hundred thousand, compared to 39 per hundred thousand in urban areas. The cost of medical care has skyrocketed and few rural families can afford basic medical care. Many skilled medical workers have fled rural areas for more lucrative work in the cities. Health service systems in Thailand have shifted from traditional cures to modern medical and health services. While the shortage of doctors is critical in rural areas, this is showing signs of improvement in the aftermath of the economic crisis.

Of all the statistics monitored by WHO, maternal mortality is the one with the largest discrepancy between developed and developing nations. The highest rates of maternal mortality in Asia are in Bhutan and Nepal, followed by Papua New Guinea and Bangladesh. Most maternal deaths could be effectively prevented if women had access to good quality affordable care during pregnancy, childbirth, and the post-partum period. Only half the births in developing countries are in the presence of a skilled attendant. Maternal illness is very high among young women. Pregnancy-related complications are the main causes of death for girls aged 15-19, who are almost twice as likely to die from childbirth as women in their 20s.

Increased medical attention, including more hospital births, is assumed to improve the health and survival rate of mothers and their newborn children. In Papua New Guinea (PNG) women continue to die at an alarming rate despite the focus on maternal and child health by missionary health workers, the national government, and international aid agencies. In Pakistan, 25,000 women die every year from avoidable pregnancy-related causes and a much larger number are left with temporary or chronic post-pregnancy illnesses. In Asia as a whole, 20-25% of maternal deaths are attributed to poorly performed abortions. Burma has an maternal mortality rate (MMR) of 580 per 10,000 live births, in the wake of induced abortions conducted clandestinely and in unsanitary conditions. In Nepal, the number of maternal deaths due to unsafe abortions accounts for 50% of all maternal deaths.

In a number of countries, abortion is either illegal or only permitted in certain circumstances, thus poor reproductive health results from unsafe abortion. Young women are particularly at risk because of unsafe abortions in countries where the medical system will not give reproductive health care to unmarried women. In many traditional societies, women are forced by custom to stay within their homes, as men cannot attend to them in health centres outside. Providing women-centred health services is one solution. In Pakistan, the problem is being dealt with by increasing the number of female health-care providers through the development of women health professionals. The concept of 'lady health visitors,' basic health care workers with a mandate to provide out-reach services, maternal and child health care has worked successfully in some rural districts.

The impact of involving women as health care providers in Tibet is demonstrated by the dramatic improvement in maternal and infant mortality rates. Seven hospitals for women and children have been set up, since which time the hospital delivery rate has gone up by 50%. Most staff at the Shannan Prefecture Hospital are Tibetans and women. Before the establishment of the hospital in 1985, the infant mortality rate was 142.3 per thousand and the pregnant and lying-in women's death rate was 78.8 per ten thousand in Nedong County. The hospital's new health system has reduced the infant mortality rate to 30.26 per thousand and the pregnant and lying-in women's death rate to 56.2 per ten thousand in 1989.

Laurence Laumonier-Ickx is a French doctor who, in 1981, journeyed to the Panjshir valley of north-eastern Afghanistan to establish a hospital and develop health services for the men, women, and children by training people from the valley. Laurence began educating the women on how to treat a fever and the importance of rehydrating the child suffering from diarrhoea. The women were quick to accept Laurence's teachings and apply them in their homes, despite them being contradictory to the knowledge inherited from their mothers. Working for Management Sciences for Health to implement the U.S. Government-funded Afghanistan Health Sector Support Project, she suggested that a family planning component be added to the training of basic health workers. The male health workers were used to serve as the conduit of information for the women. Laurence's team trained the health workers to use schools for carrying health messages home. Laurence believes that humanitarian assistance can be effective provided it is undertaken with "with sensibility, respect, and involving as much as possible those who have experienced Afghanistan before."

Since the 1975 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the 1995 Fourth World Conference on Women in Beijing, governments have increasingly called for an end to violence against women. Such violence continues to be widespread, and taking different forms – including rape, domestic violence, honour killings, and trafficking – exacts a heavy toll on the mental and physical health of women. This pervasive phenomenon is being increasingly recognised as a public health concern and a serious violation of basic human rights. Fear of speaking out inhibits discussion and constrains the health choices and life opportunities of many.

In the state of Himachal Pradesh in India, women have started talking openly about the adverse effects of alcoholism among men on the family. From the beginning of the 1980s, the Himachal government began relying more and more on excise revenue from liquor sales as a means of increasing its income. Happy homes have been converted into places of violence and abuse. Because a man's income is now squandered away on alcohol, women are forced to take on more paid work in addition to their already substantial work burden.

Even while an HIV/AIDS component has been added to some reproductive health programmes, the incidence of sexually transmitted diseases, including HIV, is on the rise among rural women in Asia. Poverty, subordination, and the lack of education and health care facilities increase women's vulnerability to infection. Each year at least 10,000 girls and women enter Thailand from poorer neighbouring countries and end up in commercial sex work. The incidence of HIV/AIDS in rural Thailand, Indonesia, and Malaysia has been on the rise since the late 1990s, also due to reverse migration of men who had migrated from the country to the city during the economic boom and were forced to return home due to unemployment during the economic crisis of the late 90s. Another country experiencing a growing HIV epidemic is Papua New Guinea where the male/female ratio for HIV/AIDS cases is 1:1.

Conclusion

The author recommends the key priority areas for action that would transform the health and well-being of mountain women:

- Access to adequate nutrition, clean water, and basic health care.
- Involvement of women's groups in decision-making at the national and community levels.
- Carrying out of baseline surveys and studies of knowledge, attitude and practice regarding the health and nutrition of women especially related to the impact of environmental degradation.
- Strengthening preventative and curative health services.
- Programmes for women should be directed at reducing the long distances that they walk to obtain fuel and fodder and minimising their risk of physical injury.
- More research on the relationship between human rights, legal and economic issues, and the public health dimensions of violence. Legal and judicial institutions need to provide adequate safeguards with regard to violence against women with specific legislation on different forms of violence.
- Policies that promote social justice, women's empowerment, and reproductive rights need to be formulated and integrated into the projects and policies of development agencies.
- An environment protection strategy should be planned in conjunction with a socio-economic development strategy.
- Provision of concrete incentives to encourage and maintain attendance of women at school and non-formal education programmes, including health education and training in primary, home, and maternal health care.
- An array of local approaches, informed by lessons learned from other places, should be supported by the right policies at higher levels.