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Good Governance Issues: Perspectives on Gender and Health Concerns

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Abstract

Women's ability to connect with the human capital resources is an undisputed fact in almost all the socio-political systems. Gender activists are of the view that women need to be provided with space and support to make optimum utilization of their potentials. Every society is expected to work towards removing the barriers that hinder women's participation in the process of governance such as patriarchy, violence, money, cultural barriers, and religious taboos.It has been seen that wherever women are empowered, there is acceleration of development. Countries that are on top of the human development index such as the Scandinavian countriesare those that give premium to women issues. UN Women is the United Nations organization that is dedicated to gender equality and the empowerment of women. Practical gender needs are immediate needs such as water and healthcare, which fall within women's socially defined roles. While the importance of these issues cannot be undermined, attention to the issues like women's status in society, transformation of power and gender relations in the context of gender equity and social justice is required.

Key words: Gender, governance, good governance, health, national goals

Governance has been defined by UNESCAP (2006) as 'the process of decision-making and the process by which decisions are implemented or not implemented'.Good governance has been defined comprehensively by UNESCAP (2006) as 'a form of governance that embodies eight specific characteristics, and can be seen as an ideal of governance. participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive, and [which follow] the rule of law'. Good governance is also gender responsive governance. Good governance[1] involves enactment of measures for positive discrimination in favour of those groups, especially women[2] that have been historically marginalized, in order to provide them with an equal platform so that they are Responsiveness to gender needs and interests can definitely promote gender equality.

Development is achieved only when the political system accepts citizens not

as passive recipients but as active participants in the implementation of the developmental programmes. In the present day context, development administration aims at bringing about a synergy between people's empowerment and goal-attainment with rural-urban synchronization and public-private partnership.Good-governance in the context of new public management puts thrust on decentralization and people-friendly and people-responsive development concerns.

Coming to the comparative view of governance in the health sector in China, Brazil, South Africa and India, it is interesting to note that for every nation, the first concern for development revolves around good health of its citizen. Health is needed for the personal hygiene of the individual, for the societal needs as well as for the overall developmental goals of the nation concerned[3]. In China, a Co-operative Medical Care System in rural areas has been established aiming at providing rural health network. As an essential feature of social insurance mechanism, the system also looks forward to helping peasants to eliminate diseases and improve their health conditions. This again assists poor peasant families inflicted by poor economic conditions and diseases in order to strengthen the rural social economy.

The role of civil society in bringing out legislative and policy changes is commendable since the advent of democracy in South Africa in 1994. Major developments in South Africa in the spheres of village reconstruction, primary education as well as health and sanitation have proved to be progressive. And the comprehensive role played by the civil society has supplemented these efforts. So far as the health initiatives are concerned, the civil society has been able to serve positive changes in laws and policies in the spheres of maternal health, contraception, termination of pregnancy, cervical and breast cancer, gender based violence, infertility, sexually transmitted infections and HIV/AIDS. A country like South Africa inflicted by apartheid for so long has made its place worthy world-wide by consolidating reproductive rights in particular and human rights in general.

In Brazil, the Constitution has taken into account most of the recommendations of CAIRO Summit (International Conference on Population & Development, held at Cairo in 1994). As a step forward towards the implementation of the ICPD Programme of Action, the National Commission on Population and Development has been established in 1995 taking representatives from government bodies, NGOs and various universities. In order to promote universal access to basic health care, the Brazilian National Health System has put emphasis on decentralization, basic care innovation and private sector regularization. By means of transferring resources and distributing responsibilities to the States and municipalities, the Ministry of Health has played a significant regulatory role in the process of decentralization. The areas on

which remarkable initiatives have been made include basic and family health care programmes and national vaccination campaign etc. Through effective participation of the civil society and government representatives in the state and municipal health councils, enhanced accountability mechanisms have been established.

In industrialized countries women have healthier life expectancy and longer life expectancy i.e. about six years more than those of men. This is vividly visible in their childhood and girls have more chances of survival in the first five years than the boys. Here comes the role of behaviour which is an important determining factor in the context of health disparity. For example, young men take greater risks, leading to injury and accidental death, and men smoke more. However, this female advantage hardly exists in parts of the world i.e. in South Asia where gender discrimination exists.

In the South Asian countries, a number of socio-demographic variables have been used in multivariate analysis to establish linkages between women education, awareness and income and alike indicators and reproductive health status of women in South Asia[4]. Efforts have been used to assess the extent to which autonomy mediates the association between education, income, awareness level and similar indicators and contraception use.

Focusing on the respective elements of the South Asian countries, various factors like the family planning and primary health care programs in each country, changes in reproductive health policy, , including demographic profile, cultural and religious environment, employment, education, the status of women. Men's role in family planning as direct users of contraceptive methods and as partners of women using methods are taken into consideration while analyzing the impact of good governance in the health and gender concerns. Also many other issues such as men's autonomy regarding family planning, pregnancy termination, obstetric care, and other aspects of reproductive health, Government's intervention in innovative health programs are taken as the baseline indicators.

In a comparative study of India, Pakistan and Bangladesh[5] it has been observed that family planning has been the most important concern of good governance. The Co-operative Medical System in China is surrounded with surmounting problems like lack of qualified personnel, lack of stable and resource mobilizing mechanism and lack of required health infrastructure etc. In order to overcome all these hindrances, the system has set up its long-term and short-term objectives and the interests shown in this regard by international organizations like WHO act as a booster towards reaching the goal

It is viewed that women in Pakistan have less autonomy or control over their lives than do Indian women .More or less, cutting across religious lines, women in

general enjoy little autonomy over their own lives in the sub-continent. Again it is revealed that in the gender—stratified structures determining the northern part of the sub-continents, women's control over their lives is more restrained than their southern counterparts.In Pakistan[6], as a result of the governmental support for family planning programme and due to the development over the last few decades, total fertility rate remains at 3.26 in 2012. It is seen that Pakistan has lower contraception use than most other Muslim Countries.Total Fertility Rate means the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given fertility rate at each age. The total fertility rate is a more direct measure of the level of fertility than the crude birth rate, since it refers to births per woman.

This indicator shows that worldwide, in developing countries, fertility and contraceptive use are related to various socioeconomic indicators. Most important determinants are women's literacy and lower income .The well -established link between female education and use of contraception plays a significant role in formulation and implementation of family planning policies in lower income countries.Women have a considerably lower social status and autonomy than men in parts of South Asia and elsewhere. Their lower fertility control and autonomy basically are dependent on their low socio-economic status.

When we come to have a glance at the role of governance in the health sector and gender in Bangladesh, it is really noteworthy that the population program has made remarkable progress over more than three decades or during the last thirty seven years. The fertility transition is already well under progress which now stands at 3.08 (2012) and the successful implementation of the immunization program is also substantial. . The crude birth rate has declined from 47 in 1973 to 29.8 in 2006 and crude death rate has also declined from 17.1 in 1973 to 8.27 in 2006. The infant mortality rate has declined from 94 for the period 1989-93 to 60.83 per 1000 live births in 2006 and life expectancy at birth has gone up to about 62.46 years for both the sexes.

Uninterrupted and strong political commitment, strategy based on maternal and child health plans and programmes, elaborate network of service providers and field workers, reaching the outreach by women, cafeteria contraceptive approach to services, decentralization of service delivery mechanism, vibrant public-private partnership are some of the factors that has led to the remarkable success achieved by the Bangladesh Population Program despite widespread poverty and underdevelopment. There are pro-active initiatives like Advocacy with religious and other community leaders, media, Inter-sectoral co-operation and extensive research on the gaps are reasons for sustainable progress and logical consequence of the good governance in gender related health issues.[7]

In India, democratic decentralization has become a reality since the 73rd and 74th Constitutional Amendments in 1992. Through these amendments, the local bodies (Both rural Panchayati Raj Institutions and Urban Local Bodies) have been assigned their functional responsibilities and ascribed as institutions of self-governance Development administration depends on the co-relation between the social development activities and their implementation through the functioning of the local bodies. In the Indian context, development in the positive health indicators could only be achieved with tiered and structured intervention. This obviously demands the synergy between political representatives on the one hand and the health administration on the other. Here comes the role of Panchayat Representatives and women representatives in specific to achieve the holistic health goal in the post-Independence era. India began its health programmes with family planning in 1951 and was supplemented by various programmes including Family Welfare Programme, the Oral Rehydration Therapy Programme, the Universal Immunization Programme and the Child Survival and Safe Motherhood Programme. After participating in the ICPD at Cairo in 1994, the Government of India launched the Reproductive and Child Health Programme throughout the country. Having learnt from all the previous experiences and feedbacks, the Government of India has ventured upon the National Rural Health Mission Programme.

For the purpose of good governance, successive governments at the Centre, have earmarked health as a special thrust area. To reach out the outreach and with the objective of providing basic health care delivery, the Government of India has launched the National Rural Health Mission on 12th April, 2005. At present, it covers almost the entire length and breadth of our country. The main objective of the Mission is to provide basic and effective quality health care to people of rural areas throughout the entire country with special focus on eighteen states having either weak public health care indicators or weak infrastructure. The specially focused states are Arunachal Pradesh, Assam, Bihar, Chhatisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim, Uttarakhand and Uttar Pradesh.

In corroboration with all the policies and programmes of the Central Government, the provinces like Odisha have also started implementing various health activities like Janani Surakhya Yojana, Navajyoti Scheme, Referral Transport, Routine Immunization Programme, Reproductive and Child Health Programme, ASHA, Universal Institutional Delivery, Increasing Obstetric Care under the broad umbrella of National Rural Health Mission. Incidentally, health statistics reveal that

the province of Orissa is found to be having the highest incidence of maternal and infant death in India. All these aforesaid programmes and initiatives would attain their goal with the whole hearted participation of the people at large at the grass-root level. As it has been embodied in the National Policy for Women Empowerment-2000 of Government of India[8], there should be de-jure and de-facto enjoyment of human rights and fundamental freedom of women[9] on equal basis with men in all spheres-political, economic, social, cultural and civil. The Policy also envisages equal access to participation and decision-making of women in social, political and economic life of the nation.

In order to have an in depth understanding of the role of women representatives in the good governance of the health sector in India, we need to know the awareness level of the women panchayat representatives, their role and extent of involvement at the implementation level of the National Rural Health Mission Programme. For the purpose of the study at the micro level, we have taken Odisha as the case study as it has the highest number of maternal deaths and infant deaths in the country. For the situational analysis, we have selected Khurda and Kalahandi districts as the highest literate district and lowest literate district of the province of Odisha respectively.

The findings of the study reveal greater degree of initiatives towards orienting the women representatives for good governance of quality health care delivery as well as convergence of various sector programmes at the grass root level. It was suggested by the respondents that for greater participatory involvement, accountability and empowerment of people including women representatives need to be ensured.

When we review the situation in Maldives, it is found that in the areas of employment, decision-making and access to higher education the empowerment of women is still in question.Because of the internal labour migration mostly the husbands remain absent from their households. Due to the high divorce rate, women head one third of all households. The status of women in family and married life has more or less improved after the implementation of the 2000 family law. The national goal of Maldives is to improve the quality of life of the Maldivian people through improved reproductive health status and the empowerment of women. The third country programme has contributed to the national goal of Maldives and works in consonance with the Millennium Development Goal.The country programme also contributes to the United Nations Development Assistance Framework (UNDAF) goal of balanced and equitable development of the Maldives. The equal participation of men and women in the social, political and economic spheres are also included as other subsidiary goals.

Studies in Nepal found that pregnancy-related mortality but not infant mortality get reduced by vitamin A or ß-carotene supplementation termination. There is a great need for careful research and application of Maternal multiple micronutrient supplementation before it is used in large-scale programs. Despite Govt. effort for good governance in the improvement of the health status of women, there is a high incidence of pregnancy-related mortality, night-blindness and deficiency of vitamins and nutrients in women. These in turn lead to overall retarded growth of women in Nepal.[10]

After the aforesaid worldwide analysis of the issue of good governance in the context of gender and health, it can be deduced that the Governmental efforts in almost all the countries are there . From the Policy implementation angle more realistic, short term, medium term and long term objectives have been drawn. As for example, while one of the immediateobjectives has been to bring family planning services into the fold of health outlets, ensuring quality in a wide range of family planning services has been the medium term goal. Making men and women aware, interested and involved in the entire process, whether short term or long term, has remained the most important mission of health strategy of almost all the nations of the world. More emphasis on service provision in family planning & reproductive health is being concentrated on improving access to quality care and as well as holistic treatment.

Despite the governmental initiatives[11] lots need to be done to improve the gender balanced health status of women especially in South Asian countries. Particularly the service delivery mechanism requires to include certain strategies like linkage with Institutional service delivery system, logistic support for infrastructure maintenance[12], Strengthening and upgrading the existing Family Welfare Centres, Public-Private Partnerships, inter-sector and intra- sector coordination reaching the outreach through culture, region and language specific advocacy and information education and communication campaigns, application of social development techniques like participatory learning approach.

References

[1] Ramesh K. Arora , Sogani , Meena, eds, (2010), *Governance in Indian Paradigms and Practices* , Jaipur : Management development academy and Alekh Publishers

[2]*Women Development Programmes in India* (2012), a Report of the Workshop held at the India International Centre, New Delhi

[3] B.B. Tondon,. Mehra, Rajneesh (2011), Towards health for all: Some suggestions to policy makers', *Indian Journal of Public Administration* , New Delhi: IIPA, Vol.57(1), January-March, pp-66-81

[4]Devaki Jain, ' Women and Development : 150 Years', *Yojana*, New Delhi: DAVP, Govt of India, 51, August 2007, pp- 73-76

[5] J. Cleland, Kamal N, Sloggett A (1996), 'Links between fertility regulation and the schooling and autonomy of women in Bangladesh' in Jeffrey R and Basu A eds. *Girls schooling, Autonomy and Fertility Change in South Asia*. New Delhi: Sage

[6]A. Moursund, Kravdal O, (2005*), Individual and Community effects of women's education and autonomy, education and contraception use in Pakistan:* a national study Reproductive Health Centre, Federal Government Services Hospital, Islamabad, Pakistan

[7]Fariyal F. Fikree & Omrana Pasa, (2004), *Role of Gender in Health Disparity: The South Asian Context*, New Delhi: Prentice Hall

[8] Government of India (1988), *National Perspective Plan for Women, 1988-2000*, Report of the Group set up by the Department of Women and Child Development, Ministry of Human Resource Development

[9] ADB (1998), *Handbook on Resettlement: A Guide to Good Practice*, Asian Development Bank, Manila.

[10] ADB (2003), *Gender Checklist: Resettlement*, Asian Development Bank, Manila.

[11] M. Asif, Mehta, L. and Mander, H. (2002), *Engendering Resettlement and Rehabilitation Policies*, New Delhi: Asian Pub.

[12] N. Satpathy *et al.,* (2002), *Women's Role and Participation in Struggles against Development-induced Displacement in Orissa and Jharkhand*, Bhubaneswar: Institute for Socio-Economic Development (ISED).