

Women and Health:

In the Context of Global Restructuring

LES FEMMES ET LA SANTÉ:

DANS LE CONTEXTE DE LA RESTRUCTURATION MONDIALE

Shanzida Farhana¹

Abstract: Recently there is a debate about the impact of global restructuring on human health. this article will attempt to examine the impact of global restructuring on the health of poor women in a range of different setting. It will also give a brief account of gender inequalities in access to health care and recent campaigns designed to resist the negative changes.

Key words: global restructuring, women's health, gender inequality, poverty, well-being

Résumé: Récemment, il y a un débat sur l'impact de la restructuration mondiale sur la santé humaine. cet article tentera d'examiner l'impact de la restructuration mondiale sur la santé des femmes pauvres dans une gamme de circonstances différentes. Il donnera aussi un bref compte rendu des inégalités entre les sexes dans l'accès aux soins de santé et les récentes campagnes désignées à résister aux changements négatifs.

Mots-Clés: restructuration mondiale, santé des femmes, inégalité entre les sexes, pauvreté, bien-être

INTRODUCTION

Restructuring does not just relate to the material but also relates to identity and many more socio-economic phenomenon. The term global restructuring has been used in a variety of ways to mean very different things. But central to all these accounts is a dramatic increase in economic, social and cultural interdependence between countries (Giddens, 1990, Lechner and Boli 2000). This has been accompanied by a greater concentration of power in the richest parts of the world and a reduction in the capacity of some nation states to respond effectively to the needs of their citizens. In many societies, these developments has led to major transformations in daily life. In recent decade has seen increasing debate about the impact of globalization or global restructuring on human health.

¹ Assistant Professor, Department of Anthropology, University of Chittagong, Chittagong- 4331.
E-mail: shanzida_farhana@yahoo.com

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There are many attempts have been made to assess the impact of these global trends on the health of populations (Dollar, 2001, Weisbrot et al. 2001). However these studies have usually been conducted at national level and the results have been of little practical value to local policy makers (Lee, 1998). Moreover, they have rarely explored the ways in which women and men might experience of globalization (Marchaned and Runyan, 2000). This article will shed light on the impact of global restructuring on the health of poor women in a range of different settings and also give a brief account of recent campaigns designed to resist the negative effects of the changes.

1. DIFFERENCES BETWEEN WOMEN AND MEN'S HEALTH

All human societies divide their populations into two social categories, which they call 'male' and 'female'. Each of these categories is based on a series of assumptions drawn from the culture in which they occur about the different attributes, beliefs and behaviours characteristic of the individuals included within that category. Other than there are obvious differences in male and female patterns of sickness and death and these are shaped by both biological and social factors. The most obvious differences between women and men are to be found in the realm of biology. Women's capacity for reproduction makes them vulnerable to a wide range of health problems if they are not able to control their fertility and go safely through pregnancy and childbirth. Similarly, both women and men are susceptible to sex specific diseases such as cancers of the uterus or prostate. Recent research has also identified differences in the vulnerability of women and men to diseases such as heart disease and TB that affect both sexes (Doyal, 2004).

But male and female patterns of morbidity and mortality are influenced not only by biological factors but also by social relationships including those associated with gender (Doyal, 1995). All societies assign specific characteristics to individuals depending on whether they are defined as male or female. There are also differences in the duties they are expected to perform and in their entitlement to a wide range of social and economic resources. This means that women and men may face different threats to their well-being while also having differential access to health promoting resources.

In order to identify the particular hazards of global restructuring for poor women we will need to take these different determinants of health into account. We will need to look at the ways in which they have been affected by changes in the patterns of waged work and domestic work and also by trends in the distribution of resources including money and time as well as health care itself. In particular we will need to look at the impact of global trends on women's capacity to control their sexual and reproductive lives.

Women, Health and Work

As Messing (1998), work is as much a part of women's life today as is marriage, pregnancy and motherhood (p.138). In recent decades many more women have taken on paid work in both the formal and the informal sectors (UN, 1999, 2000 a, b). In some countries this increased employment among females has been accompanied by a decline among males. Yet there is little evidence of concomitant changes in the gender division of household labour.

It is established that increased access to waged work can be good for women's health (Doyal, 1995). If they are able to earn and keep an independent income, it will be easier for them to buy what they need to promote their own health whether that is a better diet or a safe space to live. The workplace may also be an important source of social support. However, for many women and especially for the poorest, the conditions of work and the way it is organized will place severe constraints on the realization of these potential health benefits.

The global restructuring of production has been based on an increasing demand by employers for flexible labour that will meet their needs at the lowest possible cost. It is in this context that many of the world's poorest women have entered the labour force. Most live in countries where regulatory regimes

are weak and wages are low and as a result they often face both new and old hazards to health (Chhachi and Pittin, 1996). Exposure to new hazards is especially common in the Export Processing Zones in Asia and Latin America where women usually make up the majority of the workforce (Loewenson, 2000 and 2001). The work in these settings is usually strenuous, monotonous and ergonomically unsound, yet its damaging effects on well-being go largely unacknowledged (Doyal, 1995). In rural areas, there have also been alarming increases in the number of women whose health is damaged by exposure to pesticides and other environmental chemicals (Simms and Butter, 2002).

There is growing evidence that global restructuring has also had an impact on the nature of unpaid labour. The most continue to have the primary responsibility for domestic work which often has to be done alongside paid employment and sometimes subsistence agriculture. This leaves them carrying what has been called the double or even triple burden. These daily labours have become significantly more hazardous as a result of environmental changes associated with global restructuring. There is growing evidence for example, of the huge burden of lung disease suffered by women in some regions as result of pollution from cooking stoves (Mishra et al., 1999; Sims and Butter, 2002). Because of their responsibility for a range of subsistence activities it is usually women who are most affected by environmental degradation (Davidson and Freudenburg, 1996). They may have to walk much greater distances for wood or water, for example, and will be at risk of musculo-skeletal injuries as they scramble to acquire the necessities of life in inhospitable terrains (Doyal, 2004).

The volume of work has increased for many women because of the insecurity and the destabilization that so often accompanies restructuring. During their reproductive years in particular, the physical demands on women will be especially high while food may be in short supply (Brabin and Hakimi, 2000). Some have been forced to migrate in order to find work or to avoid situations of conflict. Others have had to search out new ways meeting family needs in old settings without traditional sources of support. In order to survive, they have to draw heavily on both physical and psychological resources and when these are depleted they will be rendered more vulnerable to a wide range of health problems (Avorti and Walters, 1999). While women may gain from new and often more lucrative sources of income, there is also a downside: deregulation of investment and conditions of production have led to worsening labor conditions, including increased casualization of employment. Higher incomes for women workers but also exposure to new health hazards and an increased workload (Hale, 1999, Messing, K. 1998).

The nature of employment in a globalizing world provides a forceful example of the between women's rights and health in the workplace. In this context, women's rights are clearly undermined through prohibitions on collective or union activity, mandatory pregnancy tests and restrictions on lavatory use. Poor factory conditions such as bad lighting, hazardous chemicals and dangerous machinery and outright abuse of women is common. Work is often physically arduous, and women are exposed to oppressive and dangerous treatment, including sexual harassment and rape (Hale, 1999). Nevertheless, protecting women's reproductive health and rights in their role as workers in the health sector or elsewhere is rarely discussed in the context of global social policy, health sector reform or reproductive health strategies.

2. GENDER, HEALTH AND POVERTY

It is often men and not women especially not younger women who make decisions about household expenditure, regardless of who earns the money. Social norms, which tend to favor men's well-being over women's, influence patterns of household expenditure which can act against women's interests. Gendered criteria for the allocation of work are mirrored by gender inequalities in the allocation of resource. Women and men are expected to do different kinds of work and they are unequally rewarded for the labours they carry out. In most societies the pattern is one where men have greater entitlement than women to many of these sources necessary for health. In many parts of the world the processes of global restructuring have exacerbated these existing inequalities, sometimes casting them in new forms.

The scarcity of gender disaggregated poverty data makes precise estimates of the feminization of poverty impossible. However, a number of studies have indicated that more women than men are in poverty in most countries. They may fall into poverty by different routes and this may impact differently on their daily lives and on their health. Women are more likely than men to be impoverished as single heads of households, for example, and they may also be the 'poorest of the poor' in those families where there is gender bias in the allocation of resources (Messer, 1997). Under these circumstances, they are especially vulnerable to the health problems traditionally associated with lack of resources.

Poverty also shapes the health of women and men in more indirect ways as the changing nature of the HIV/AIDS epidemic illustrates (Farmer et al., 1996; Cordon and Crehan, 1997). In situations where they have few options for supporting themselves and their families, many women may feel compelled to stay with a male partner even when this is putting their life, at risk.

Similar links can be made between the gendered nature of poverty and the health burden of intimate violence. Of course, violence against women is found in all society and culture and not only just among the poor. However a growing number of studies indicate that it is often exacerbated under the conditions of insecurity and social conflict that so often accompany restructuring (Narayan, 2000; Garcia Moreno, 2002). Men may feel abate as they lose their sense of identity and social status while women's lack of access to financial and other resources forces them to remain in dangerous homes (Doyel, 2004).

Gender Inequalities in Access to Health Care

Gendered inequalities in access to resources in general are also evident in the specific context of healthcare itself. Women's reproductive capacities mean that they have special needs which must be met if they are to realize their potential for health. But there is growing evidence that changes accompanying global restructuring have placed new constraints on the ability of some women to meet both their sex specific and also their more general health care needs.

In many parts of the world, global restructuring has included policies designed to reshape the political economies of developing countries. These initiatives have had a particular impact on the delivery of health care (Cassells, 1995). During the 1980s and early 1990s the combination of economic crisis and structural adjustment policies led to a dramatic decline in both the quality and quantity of public services, especially in the poorest countries.

The cost of health care rising dramatically with the introduction of user fees, a major flight to the private sector and an increase in out of pocket expenditure (Kutzin, 1995). Studies to evaluate the impact of these developments have been rare and few have been gender-sensitive. However, the evidence suggests that women have often been disproportionately affected (Standing, 2002). For most people in low- and middle-income countries, the use of public services involves a cost in terms of transport, time, unofficial fees, provision of bedding and food, etc. Many of these costs are borne by women. In most poor countries, the majority of people rely on the private sector, either formal or informal, to treat many illnesses, and the public sector is often the least used health service.

Literature of women's health seeking behaviour suggests that women's ability to pay needs to be defined from a gender perspective, taking into account their access to and control over resources and decision-making about health. Further, their willingness to pay is determined by the social costs of health care, including factors such as perceived quality of care.

Despite the high profile of the International conference on population and Development held in Cairo in 1994, sexual and reproductive health remains low on the agenda of health sector reformers (Subramaniam, 1999; Nanda, 1999). The main focus has been on reshaping financing mechanisms and human resources with relatively little attention paid to the type of the care offered.

The Experience Health sector reforms have been criticized for failing to fully support women's reproductive health and rights. In practice, reproductive health in health services tend to focus on family planning, limited prenatal care and obstetric care and to cover interventions in women's child bearing activities. Some programs include a minimum of gender training. Adolescent girl's and especially older

women's health tend to be marginalized. In practice, the relevance of men in reproduction is barely reflected in reproductive health priorities. Thus, women's right to health is limited to their reproductive health during their child bearing age and not at all stages of their lives. Violence against women, which affects women's and girls health at all ages, while recognized by the World Bank as a threat to their health, has received very little attention. Despite the focus on child bearing years, women's reproductive rights have been curtailed (Desai, 2004).

Under these circumstances, reproductive health services have been side lined. Their centrality to women's health has not been recognized and this has contributed to continuing high levels of maternal morbidity and mortality (Hill et al., 2001).

3. THE TARGETING APPROACH

The targeting approach shows little appreciation of the ways in which gender inequalities among both providers and users of health services have an impact on the causes of poor health among the population as whole. Most health program support is directly channeled to public provision of basic or 'essential services' targeted to the poor. The Bangladesh example is common, where the health sector program calls for the allocation of the bulk of public expenditure to primary health care, providing an essential package of services (EPS) and encouraging the private sector to take over some urban-based hospital services which are considered non-essential and tend to be used by higher-income groups (Elson and Evers, 1998).

In fact, the targeting women approach fails to address society-wide gender inequalities. Most sector programs target poor women to strengthen reproductive health and gender equity in health. However, the targeting approach is partial and ineffective as a tool of gender-aware health strategy (Elson and Evers, 1998; Gilson, 1998). For instance, gender disaggregated indicators may show that most health clinics do not have women doctors, so gender-specific policy components may target expenditure for training more women doctors. However, without addressing the special problems women face in finding the time and money to travel to and from a clinic, regardless of the presence of a female doctor, women's needs will not be adequately met. In a report for UNICEF, Vandemoortele (2000) concludes that narrow targeting of services to the most needy is likely to yield savings that are "penny-wise but pound-foolish."

By relying on better targeting, health sector reforms do not consider the ways in which gendered norms pose particular difficulties for women providers and users, such as the problems faced by women doctors in re-locating to rural areas or women's tendency to undervalue their own health needs in comparison to those of their children and husbands.

Women and Global Restructuring : In the Context of Health Politics

It should be take into account the circumstances of women's lives and not assume that all mothers have only one job to do look after their children. As the effects of global restructuring have become more visible many women have responded by be coming involved in political action (Basu, 1995). Not surprisingly their campaigns have been firmly rooted in everyday life as they have talked the challenges of survival in the context of uncertainty. The methods used have varied by time and place but health has been a central focus (Doyal, 1995, ch 8).

The most intensive campaigning has involved sexual and reproductive care and gender violence (Bennett and Manderson, 2000). But women have also been involved in a variety of need-based campaigns relating to poverty and subsistence (Rowbotham and Linkogle, 2001). Both occupational and environmental health have been high on women's political agendas as global restructuring has exposed both them and their families to new hazards.

Women's lack of decision-making power in all spheres of life undermines efforts to strengthen

women's reproductive health and rights. Multi-pronged approaches to supporting women's human rights in all spheres including the right to adequate primary health care, housing and social security as well as strengthening women's rights in law, employment, education and political life need to take a more prominent place in advocacy and policy strategies. Most importantly Women have been especially active in this context with many moving from the role of volunteer service provider to community activist (Basu, 1995). At the same time, some of those entering the labour force have become involved for the first time in collective action to defend themselves against threats to their well-being (Hale, 1996; Parveen and Ali, 1996).

For some women, the expansion of their sphere of activity has been especially dramatic. Moving beyond the confines of their own communities they are now working to promote global health in both national and international contexts. Using new information technologies and deploying the universalizing framework of human rights they have highlighted the potential of virtual communities in a globalised world. Despite major differences in material circumstances and socio cultural identities they have worked together to promote more equitable gender relations as part of the wider campaign for a healthier world (Castells, 1998; Keck and Sikkink, 1998; Kickbusch, 2000;).

CONCLUSION

The impact of globalization on health is very complex. Changes take different forms in different places and culture. Impact on individuals varies with age, ethnicity, socio- economic status and both sex and gender important aspects of this diversity. Now there is need for more research on differential impact of global restructuring on health of women and men. More detailed studies needed of complex and contradictory effects of change on well-being of women and men in different settings. These will provide basis for improved policy making in the health sector and other social advancements.

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