Education and Health in South Asia: What Do We Know?

Despite progress made in all the South Asian countries in expanding health facilities and services, the morbidity and mortality situation of women continues to remain unsatisfactory. Malnutrition, caused by a combination of low incomes, inadequate or poorly balanced diets and poor food hygiene, has been one of the key determinants of ill health among the poor; and women are at a much greater risk than men

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During the last decade, at least three international conferences (the World Conference on Human Rights in Vienna in 1993, the International Conference on Population and Development in Cairo in 1994 and the

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Fourth World Conference on Women in Beijing in 1995) sought to reshape a vision of women's lives by placing gender equity, women's rights, empowerment, health (including reproductive health), quality of life, equality and freedom at the centre of population and sustainable development policies and programmes. In the period since these international events, almost all States, as signatories of the action agendas of the conferences, have attempted to move closer to fulfilling many of the commitments. In this endeavour, they have also sought the help f both national and international non-governmental organizations, institutions and corporate sectors. However, certain challenges remain for many of the countries in terms of access to services for some of the marginalized groups. Perhaps more innovative approaches rather than the standard poverty alleviation approaches are needed to bring all within the fold of development.

In the last three decades, almost all countries in the ESCAP region have made noteworthy progress in improving women's overall status and more specifically their health and education indicators, two areas where female disadvantages have traditionally been conspicuous. In the first section, this paper outlines the achievements or improvements made in access to the basic health and education status of women in four countries in the Indian subcontinent (Bangladesh, India, Nepal and Pakistan; however, Sri Lanka and the other small or island countries are omitted). The factors that constrain progress in achieving the goals set by the international conferences such as the International Conference on Population and Development as well as by the countries themselves, are also discussed. The measures needed to reach the goals to improve the health and education status of women in these countries are outlined in the subsequent section. Unequal access to development associated with poverty is a cross-cutting theme throughout the paper.

All four countries have articulated women's concerns and made provision in their plans and programmes to address those concerns and their development. However, despite the rhetoric and some measures that have been initiated, women's participation in almost all sectors remains very limited. This is a consequence of both their low educational achievements and the biases favouring males in all walks of life. The persisting gender disparities in regard to various benefits and opportunities are brought out by the data and analyses presented below.

The data quality, breadth of issues covered and the time duration for which information on various indicators is available vary a great deal between the countries under consideration. An effort is made, however, to cull out those data which are more or less comparable in terms of both estimations and the time period to which they refer. They do provide the flavour of the prevailing situations in each of the countries and also point to the country-specific issues. Except for Nepal, the countries are large in terms of population and show wide interregional variations within them. However, in the broad canvas that is presented here, it is not possible to address this important issue. Wherever appropriate, reference will be made to the differences within the countries.

Access to education

Illiteracy contributes to women's marginalization within the family, workplace and public arena. The large gender gap prevailing in most countries in the South Asian region in levels of education results in women's powerlessness or non-involvement in decision-making at home. Illiterate women are also caught in a vicious cycle of poverty, repeated childbearing and ill-health. At the workplace, women without education are engaged in low-paid irregular wage employment, work long hours and also face the threat of unemployment. In the public arena, they face indifference or receive scant attention from providers of health-care or other services. Education is essential to enable them to break out of this predicament. The advantages in providing education to women have been well established throughout the world. It elevates women's status in all spheres of life and decisively determines their access to paid employment, earning capacity, overall health, control over fertility, family size, spacing of births and decision-making. Educated women are able to ensure that their children, both boys and girls, attend school, receive good-quality education and have access to health care.

However, until recently South Asia countries have had practically no tradition of providing education to women. When they adopted universal primary education as a fundamental goal, barely 3 to 7 per cent of women were counted as literate in India or Nepal. The situation in Bangladesh and Pakistan was equally dismal. Since then, there has been a considerable increase in the enrolment of girls at the primary level of education. While the gender gap in literacy has somewhat narrowed because of the rapid increase in the literacy level of women, there is still a long way to go in universalizing education among girls. To provide education to all in the South Asian countries would require not only strong political will, serious bureaucratic commit-

Table 1. Changes in the educational profile of women and men in South Asian countries, various years

	Male	Female	Male	Female	Male	Female
Bangladesh	**1974**		**1981**		**1991**	
Percentage literate in 10 and over population	37.2	13.2	39.7	18.8	45.5	24.2
Percentage literate in 10-14 age group	37.9	28.1	—	—	—	—
Percentage literate in 20-24 age group	14.2	1.1	12.2	2.3	—	—
India*	**1971**		**1981**		**1991**	
Percentage literate in 10 and over population	49.9	22.6	57.0	29.0	64.3	38.1
Percentage literate in 10-14 age group	59.8	38.1	66.8	44.8	77.0	59.7
Percentage literate in 20-24 age group	60.7	28.7	66.6	37.1	71.5	43.8
Nepal	**1971**		**1981**		**1991**	
Percentage literate in 10 and over population	24.7	3.7	34.0	12.0	54.5	25.0
Percentage literate in 10-14 age group	—	—	50.8	21.2	76.0	49.3
Percentage literate in 20-24 age group	—	—	41.7	12.6	64.3	26.3
Pakistan	**1972**		**1981**		**1991**	
Percentage literate in 10 and over population	30.2	11.6	35.0	16.0	—	—
Percentage literate in 10-14 age group	31.4	16.4	31.3	19.6	—	—
Percentage literate in 20-24 age group	40.3	15.7	46.0	22.8	—	—

* For India, the category ''literate'' also includes those who report themselves as literate without any formal schooling.

Sources: United Nations, 1995, 1996, 1997; Visaria and Ramachandran, 2002.

ment, mammoth investment in the development of infrastructure, such as school buildings and teacher training, but also social engineering in order to mobilize the parents to send their daughters along with their sons to schools.

As shown in table 1, all four countries have indeed made considerable progress in providing education to women and men in the past three decades. It may, however, be noted that the increase in education is a recent phenomenon in all the countries. The spurt occurred in India a decade or two earlier than in the other countries and, although recent data for Pakistan are not available, its education revolution has just begun.[1] All the same, the backlog of illiterate population will remain with all the countries for the next four or five decades. Around 1990, only 24 per cent (Bangladesh) to 38 per cent (India) of females 10 years of age and over and 45-64 per cent of adult men in this region were

reported to be literate. Since then, in the past 10-year period, these countries have reportedly made significant progress in improving the literacy status of its young population; however, detailed data from the latest round of censuses are yet to become available.

Further, the literacy level is considerably higher in the urban areas compared with rural areas in all the countries (not shown in the table). In Bangladesh, for example, according to the 1991 data, the urban female literacy rate of 52.5 per cent was more than twice the corresponding rural rate of 20 per cent. For the same year in India, 31 per cent of rural women were reported to be literate as against 64 per cent of urban women (the 2001 census data are not yet published).[2] During the past three decades, Nepal has also made considerable progress in developing its national education system. Despite a significant improvement in the proportion of literates in the population since 1971, only a quarter of the adult females were reported to be literate in 1991, the majority of whom live in urban areas. Although data for the 1990 decade are not available, the situation in Pakistan is likely to be much more dismal, partly because until recently there was no tradition of providing education to women in many parts of the country. Concerns of safety of girls, limited supply of female teachers etc. have hampered providing literacy to girls.

The fact that the spread of education is a recent phenomenon is evident in the data in table 1. Nearly 76 per cent of boys and 50 per cent of girls aged 10 to 14 were literate in Nepal in 1991 (as against 42 and 24 per cent of men and women aged 10 years and over, respectively). India is the other country for which similar data are available; it shows a similar pattern, with a much higher percentage of children than adults (77 per cent of boys and 60 per cent of girls aged 10-14 years were reported to be literate) as literate. The 1991 figures for Bangladesh and Pakistan by age are not available but the situation is unlikely to be different. Among the 20-24-year-old young adults in 1991 who would have enrolled in school in the mid-1980s, the percentage literate among men ranged between 65 and 71 per cent, but among women, between 26 and 44 per cent, with Nepal at the lower end and India at the higher end of the scale. This suggests a gender lag in the provision of education; boys began to receive education in large numbers earlier than girls, who began to enter schools in large numbers a decade or more later.

The overall literacy rates do not give an indication of the level of education that the women and men attain. One summary measure available is the mean number of years of schooling estimated for the adults 25 years and

Table 2. Mean years of schooling (25 and over) in South Asian Countries, 1980 and 1990

Country	1980			1990		
	All	Male	Female	All	Male	Female
Bangladesh	2.0	3.1	0.9	2.0	3.1	0.9
India	2.2	3.3	1.1	2.4	3.5	1.2
Nepal	1.8	2.7	0.9	2.1	3.2	1.0
Pakistan	1.7	2.7	0.7	1.9	3.0	0.7

Sources: United Nations, 1995, 1996, 1997; Visaria and Ramachandran, 2002.

over, for years around 1980 and 1990. Estimates given in table 2 clearly indicate that in 1990 males and females had received on an average three and one year of schooling, respectively. The situation had marginally improved in one decade but is not very different in the four countries under consideration. The implications of such a low level of education for the well-being of the population in general and women in particular are discussed in a later section.

Some further data on education presented for the four countries in table 3 suggest that school participation by girls relative to boys is much less and girls drop out of the school system earlier than boys do. Despite the fact that equal access to education opportunities for both sexes is guaranteed by Bangladesh's constitution, and girls comprised almost 45 per cent of the primary school-age population, the participation of girls in the education system was significantly lower than that of boys. At the secondary level, only 15 per cent of all girls were enrolled in school as against 32 per cent of boys, and girls comprised 34 per cent of all children. At the higher level of education, the share of girls would be even smaller. Further, while in recent years a large percentage of children in the primary school age group may be enrolled in schools, the percentage of those attending classes regularly is likely to be much smaller, and more so in the case of girls. As evident in the average number of years of schooling, the completion rate of even the primary cycle is very low. The drop out of the system at various stages of the primary cycle occurs even before attaining the minimum educational standards or literacy skills. Poverty, non-conducive social norms and values and insecurity are important factors contributing to the high dropout rates in Bangladesh.

The Nepalese Government had subscribed to the goal of achieving universal primary education by the year 2000 and has made the five-year primary education programme starting at 6 years of age officially compulsory and free of charge in government schools. Considerable efforts have been

Table 3. Education profile of countries in South Asia, decade of the 1990s

Item	Bangladesh	India	Nepal	Pakistan
Female teachers as percentage of total				
Primary	—	—	—	—
Secondary	10	36	10	15
Female pupils as percentage of total				
Primary	48	45	42	32
Secondary	51	38	38	31
Adult illiteracy rate (aged 15 and over)				
Male	48	32	42	43
Female	71	56	77	73
Youth illiteracy rate (aged 15-24)				
Male	40	21	24	30
Female	61	36	59	59
Combined primary/secondary gross enrolment ratio				
Male	49	81	94	53
Female	38	62	53	26
Children out of school (percentage of age group)				
Primary — Male	20	17	7	—
Primary — Female	30	29	38	—
Secondary — male	73	29	32	—
Secondary — Female	84	52	60	—

Sources: United Nations, 1995, 1996, 1997; Visaria and Ramachandran, 2002.

made to expand primary school education and increase the participation of girls in schooling, by establishing schools in remote areas, providing free tuition and books and giving special incentives to encourage teachers to work in these areas. Despite these efforts, and a dramatic increase in enrolment at the primary, lower secondary and upper secondary levels of general education, available data indicate that girls lag behind boys in school enrolment,[3] and in literacy and educational attainment. In 1991, girls constituted only 37.2 per cent at lower secondary and 28.7 per cent at upper primary levels. Further, about half of the males and three fourths of all females in the appropriate age groups were not participating in secondary education. The low level of literacy among females in Nepal is due to social prejudices against female education, restrictions on their mobility and their overall low social status. The system of early marriage further leads to lower participation by women in formal education.

In recent years, the Government of Pakistan has also accorded priority to education; however, allocations to the education sector have until recently been around 2 per cent of gross national product, one of the lowest levels in the world. Consequently, all levels of Pakistan's education system have been underdeveloped and underfinanced, in both absolute and relative terms. Pakistan continues to have very high illiteracy, low rates of participation and very limited educational opportunities for many children, particularly for girls in the rural areas, despite a dramatic increase in student enrolments at the primary, middle and secondary levels in the late 1980s and early 1990s. However, despite the increases, girls constituted only about 31 per cent of all students enrolled at the primary and middle levels of education in 1993-1994. Although reliable and up-to-date information is not available, it is generally accepted that nearly 50 per cent of girls who enter the primary level at grade 1 drop out before completing grade 5 and the highest dropout rate occurs between grade 1 and 2. The low enrolment and high dropout rates, particularly for rural girls, are due to a number of reasons such as poor physical facilities in schools, long distance to school and shortage of teachers, especially of female teachers. Further, schooling in Pakistan involves substantial cost to parents, which influences their decision about sending girls to school given the economic and sociocultural constraints.

Given the inadequate investments in education by the Government, resulting in inadequate school facilities in terms of separate schools for girls (only about a third of primary schools are for girls), and an unsafe school environment, religious schools have become an alternative avenue for the education of girls in rural areas where there are no facilities for primary education or where the primary schools are located at a considerable distance from the village. In the mosque schools, the Imams teach children Islamic studies and in the Mohallah schools literate women in the local area teach girls the Islamic studies and skills of home management. The very low female enroment in formal schools implies that a very limited pool of educated women from which teachers are recruited is available in Pakistan, which in turn further limits the educational opportunities for girls, particularly in the rural areas.

India, on the other hand, appears to be in a somewhat more fortunate position with regard to enhancing enrolment of boys as well as girls at the primary level compared with its neighbours. The Government's efforts to provide schools throughout the country seem to have contributed to the

achievement.[4] Despite the criticism that a significant proportion of rural schools are single-teacher schools, the statistics suggest that enrolment at the primary level has become universal for boys and that girls are not lagging far behind throughout India. However, household data collected by the National Sample Survey do not fully corroborate the official service statistics. For example, as opposed to officially 82 per cent of all girls enrolled at the primary level of education in 1996, the Survey reported 68 per cent of girls being enrolled and 63 per cent attending school. According to the 1991 census, 45 per cent of all girls and 39 per cent of rural girls aged 6 to 10 years were reported to be attending school.

However, evidently the decade of the 1990s has witnessed a major achievement in school attendance in India. The overall achievements, however, mask the important fact that the spread of education has been quite uneven. Not only do women continue to be at a disadvantage compared with men, but this also applies to rural areas as compared with urban areas. Within rural areas, certain segments of the society, such as those belonging to scheduled tribes and other economically and socially backward groups, have lagged behind. The stated reasons for non-attendance at school for girls have ranged from high cost of education, lack of interest in studies, and the perception of parents that education is unnecessary for girls. Lack of proper school facilities and marriage, were also important reasons for girls not going to school or dropping out of schools. These reasons have to be understood in a wider context in order to evolve appropriate policy prescriptions.

Health care: existing situation and access

South Asia is the only region of the world where men outnumber women in the total population.[5] This deficit of women relative to men stems from various forms of lifelong discrimination against girls and women, particularly from the inferior nutrition and health care that girls receive early in life and during their childbearing years. Even though women are the main providers and carers of family members, their own health needs are inadequately addressed almost everywhere. In all the four countries of the Indian subcontinent under review, boys are more valued than girls, who have less access to health care. Discrimination is reflected in the female infant and child mortality rates, which are higher for girls than for boys.

Table 4. Health Profile of South Asian Countries, various years in the decade of 1990s

Item	Bangladesh	India	Nepal	Pakistan
Life expectancy at birth				
Male	60	62	58	61
Female	60	63	57	63
Life Expectancy at age 60				
Male	15	16	15	17
Female	16	17	16	18
Infant mortality rate				
Male	78	67	81	75
Female	79	78	84	73
Child mortality rate (1-4 years)				
Male	14	29	NA	9
Female	16	42	NA	10
Maternal mortality rate	600	440	830	200
Prevalence of anemia (percentage of pregnant women)	53	88	65	37
Percentage of women receiving pre-natal care	23	62	15	27
Percentage of all births attended by skilled health staff	12	42	11	18
Percentage women among adults with HIV/AIDS	15	24	40	19

Sources: United Nations, 1991, 2000.

Although data on food distribution within the household are difficult to collect, there is enough microlevel evidence to show that it is not always equally distributed among all family members. In all South Asian countries, there is a practice of men and boys eating first, and whatever is left is then distributed among the girls and women. Invariably, the adult women end up eating less food that is of inferior quality and nutritive value. As a result, girls and women in these countries are much more likely to be malnourished or anaemic compared with boys. These practices are further aggravated when family incomes shrink; women are the major sufferers of deprivation.

Table 4 presents a comparative picture on several health indicators derived from recent data available from the countries. The life expectancy at birth and at age 60, shown in the table, indicates that, except for Nepal, women in the countries concerned live slightly longer than men (about one year). However, until very recently, this was not the case. Men outlived women in this entire region for several decades. With the spread of immunization services and the control of many of the communicable diseases, the natural biological advantage of women has finally taken precedence. The female

advantage in life expectancy at birth is expected to increase in the coming decades in all the countries.

The life expectancy of women at older ages (at age 60 and above) is also about a year higher than that of men. A somewhat higher life expectancy of women compared with men at older ages implies that women will have to spend a part of their old age without partners because, besides living a little longer, women tend to marry older men and do not generally remarry when widowed. Given their minimal literacy attainment, the elderly women are more likely than elderly men to live in poverty. Further, widowed and other women are also restricted in their employment opportunities, property rights and social behaviour and movement in public space.

On the other hand, the infant mortality rate for girls in the early 1990s was slightly higher than that of boys in Bangladesh and Nepal, and significantly higher in India. Pakistan was the only exception, with a female infant mortality rate lower than the male rate by two points. At the same time, female child mortality (mortality at ages 1 to 4 years) is significantly higher than male child mortality in all the countries. Not only that: there has been no improvement in the relative death rates of females at childhood ages; if anything, the situation seems to have worsened. Preference for sons is widespread throughout this region. Studies conducted in these countries have shown that behavioural factors, including care-seeking practices, operate against young female children. Girls are less likely to receive medical attention than boys, and if they do receive treatment it tends to be at a later stage of illness and provided by less qualified personnel (Waldron, 1987). Many of the discriminatory practices involved are subtle and lie deep within intimate family behaviour.

In the entire South Asian region, it is difficult to obtain reliable estimates of maternal mortality. In Nepal, the indirect estimates of maternal mortality rate have ranged from 510 per 100,000 live births for the country as a whole, to 850 based on three rural districts (United Nations, 1996, p. 21). The levels observed in the neighbouring countries of Pakistan[6] and Bangladesh and in certain States of India are also similar. The high maternal mortality in this region is attributed to several causes, such as complications during pregnancy and delivery, indirect obstetric causes such as aggravation of pre-existing conditions, and deaths arising from a condition not related to pregnancy but occurring within 42 days. In Pakistan, an estimated 20,000-30,000 women die every year from complications of pregnancy, childbirth or unsafe abortion. Again, the majority of maternal deaths that occur during or soon after birth are

caused by haemorrhage, sepsis, toxaemia, labour and primitive abortion methods.

Except for Pakistan, the prevalence of anaemia among pregnant women in the countries concerned exceeds 50 per cent; in other words, more than half of all pregnant women are anaemic. This adversely affects not only the health of the mothers but also of the infants born to them. A sizeable proportion of infants are born with low birth-weight.

In Nepal, less than 10 per cent of deliveries take place in a health facility and, given the mountainous terrain and poor road and transport network, access to emergency obstetric care is virtually impossible for most of the rural women. In Pakistan also, a very substantial percentage of birth deliveries take place at home with the help of *dais* or traditional birth attendants. According to the 1990-1991 Pakistan Demographic and Health Survey, 52 per cent of all births were attended by *dais*, while relatives attended another 12.5 per cent.

Although the majority of current HIV infections are still among men not only in the world but also in South Asia, AIDS is increasingly spreading among women. The recent estimates suggest that almost 40 per cent of HIV/AIDS cases in Nepal are women. While the proportion in the other three countries is small, there is no reason to be complacent. Largely monogamous women are increasingly exposed to the infection owing to the behaviour of their husbands.

The other major health problems faced by women stem from poor environmental sanitation, high prevalence of communicable diseases, nutritional deficiencies and parasitic infections. Despite the progress made in all the South Asian countries in expanding health facilities and services, the morbidity and mortality situation of women remains unsatisfactory. Malnutrition, caused by a combination of low income, inadequate or poorly balanced diets and poor food hygiene, has been one of the key determinants of ill health among the poor, and women are at a much greater risk than men. The problem is aggravated by cultural barriers, which prevent women's mobility to access health care when it is not available within the village where they live. It is also aggravated by the fact that many rural health institutions, such as primary health centres, have problems in attracting staff at all levels. This problem is even more acute with respect to female paramedical personnel owing to the severely restricted supply of qualified girls and problems of their safety in remote locations.

Challenges ahead

In the developing countries, including those of South Asia, health sector reforms are being implemented and issues related to financing, resource allocation and management have become very important. We need in-depth and dispassionate research on what impact these reforms have on the poorer sections of the societies and particularly women. Women comprise a large segment of the vulnerable population group in these countries and since access and the utilization of heath services are influenced by cultural and social factors, we need to highlight the gender issues in health sector reforms. Especially in this context, issues such as the introduction of user fees and what impact it would have on the access of women to health care must be fully understood. Questions such as whether vulnerable groups will be appropriately served by the private sector must be addressed and debated (Filmer and others, 1998).

Another challenge is involving women themselves in some way in the design, implementation and evaluation of both health and education policies and programmes. Their voice must receive more than token representation. Along with that, the policy makers and concerned personnel of both health and education departments will have to be educated to ''listen'' to women.

We also need to understand why the poor are less educated and suffer greater mortality and morbidity. Many of the determinants of illiteracy and poor health would require taking a broader view and going beyond the health or education sectors. Issues of sanitation, clean water, employment etc. are all closely interlinked and a holistic approach would be needed if we aim at the well-being of all, including women.

Also, innovative approaches such as providing support for girls' secondary education in Bangladesh (where girls have been exempted from paying tuition fees and are given cash incentives) need to be carefully reviewed for possible upscaling. Similarly, the education guarantee scheme of Madhya Pradesh in India, which has reportedly increased school participation among girls from backward communities, also need to be carefully evaluated for possible lessons and replication in other parts of the country.

Endnotes

1. Overall, India has fared better than its neighbours and declared to provide free and compulsory education to all children by 1960. The goal of universal education even today remains elusive but certain pockets, such as the southern State of Kerala, have managed to nearly

universalize literacy but the proportion of literate girls has been very small in the tradition- and caste-ridden north Indian States of Uttar Pradesh and Bihar.

2. According to the National Family Health Survey, two conducted in India in 1998-1999, 72 per cent of urban women and 44 per cent of rural women were reported as literate. The corresponding figures for men were 87 and 69 (see: IIPS, 2000).

3. Gross enrolment ratios include under-age and over-age students as well as repeaters, and thus tend to exaggerate the enrolment situation.

4. According to the latest Education Survey available for 1993, 83 per cent of habitations and 94 per cent of the population in India have a primary school within a distance of one kilometre. It is in the very small villages and hamlets located in remote areas that schools have not been set up. However, alternative schools have been set up in many such areas in the last 8-10 years, which has resulted in a tremendous increase in enrolment at the primary level (Visaria and Ramachandran, 2002).

5. In the case of Nepal and, to a smaller extent, Bangladesh, the excess of females in the total population is explained in terms of net emigration of men to countries like India in search of work. However, males have outnumbered women in the young age group 0-14 in both these countries — a fact that can be explained largely in terms of higher female infant and child mortality compared with male mortality.

6. Several United Nations reports have estimated the maternal mortality rate for Pakistan at 600 per 100,000 live births in 1988, while the Government's Eighth Five-year Plan estimates the rate at 300 for 1993.

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