Vol. 13 No. 1 2007 ■ ISSN 1394-4444

ARROWs For Change

Women's, Gender and Rights Perspectives in Health Policies and Programmes

Published by the Asian-Pacific Resource & Research Centre for Women (ARROW)

Rural Women's SRHR:

Knowing the Complexities for Strengthening Strategies

Rural women's sexual and reproductive health and rights (SRHR) are not simple and straightforward issues that can be addressed effectively and efficiently through universal blueprints developed in urban centers. They represent a complexity and dynamism that need to be understood because strategies to address the concerned issues would have to be placed within the domain of these complexities.

Illustration by Grace de Jesus-Sievert/Isis Int'l.-Manila Collection

Just as complexities may vary, because of the very difference in what constitutes 'rural,' strategies too could vary on the basis of women's empirical realities. (For example, strategies and outcomes in areas where there is greater female literacy may be different from those in areas where female literacy is very low.) Similarly, complexity could also present itself differently on the basis of the ideologies of the country concerned. A welfare state, for example, would be more responsive to the needs of its population than a state governed by market ideology. Furthermore, the robustness of health professional organisations, especially the public/community health associations, could play a critical role in addressing the SRHR of rural women. For example, the American Public Health Association has a very active peace caucus and has a group named *health-not-war*. These and other groups champion structural changes for improving health outcomes. Last but not the least, the health of women's movements in any country could also play a critical role in raising SRHR issues not only within the heath sector, but also with other relevant ministries and political parties.[1]

What does SRHR really mean? Does sexuality only mean sexually transmitted infections? Should one be satisfied if the public health sector offers a reproductive health package that includes treatment for sexually transmitted infections? If the answer is NO, then one has stepped into a realm that has not yet become a part of mainstream education or of discussions in many groups working on SRHR. While social determinants of health have become a fairly well understood concern, not many are talking of determinants of sexuality. Coercive sex within marriage is a sexuality issue that few health care professionals grapple with. The question of who controls their sexuality—women themselves or social norms—is a priority issue of only a few feminist groups in many Asia-Pacific countries. However, who explores the nature of interaction between such feminist groups and RH practitioners? Both sides could be guilty of ignoring the other!

Reproductive health, because of the International Conference on Population and Development (ICPD), has acquired greater recognition within the government and non-government sectors of most countries. However, if health is interpreted only as a medical issue, and the social and mental health[2] of women are ignored, then reproductive health loses its rights perspective. Thus it must be acknowledged that the way the notion of rights is interpreted within the health sector is very different from how it is interpreted by human/women's rights groups. It is also worth noting the extent of health activism in a country. Rights activists in countries seeped in anti-women traditions face herculean tasks in getting those in power to make women's health determinants a priority area. It is not enough to espouse women's rights, expecting women to suddenly stand up and demand them. Strategies that bring forth the notion of responsibilities of the State and society to recognise and to address women's rights also need to be identified. After all, rights are not to be found in isolation of the context within which they are violated or upheld. Moreover, rights are not merely an issue of individual's responsibility to exercise her agency. Social customs and even laws create barriers to women exercising their own agency. Whether strategies to mobilise women for better SRHR engage with this extraordinary challenge of women striding out of their socially constructed roles is something to reflect over and analyse. For, if this were happening, there would have been a rapid improvement in health indicators as well as in indicators of social determinants and determinants of inequities.[3]

Just as there are complexities around the very notions within SRHR, there are complexities around the notion of 'rural.' What is the meaning of rural? Is it one homogenous phenomenon that is not urban? Women's health, in terms

of health outcomes and of access to health facilities, is often analysed from the urban-rural perspective. Those directly concerned with women's health in general, and reproductive health in particular, are conscious of inequities on the basis of geographical location. This is an important equity dimension,[4] and presents a convenient distinction to highlight differences. However, it is also important to note that urban-rural differences could hide other inequities—those of inequities *within* the differences, which sometimes can be as varied as those between urban and rural health outcomes. For example, rich women living in rural areas are likely to have health status comparable to that of urban women of high income levels. Thus, it is not the rural area *qua* rural area that is likely to create vulnerability. Other social structures, like class, race, ethnicity and caste, can also present inequalities within the rural sector.

The complexities within rural areas are sometimes glossed over as well. What is termed 'rural area' could be anything from rich, fertile land to arid land, desert or semi-desert region; it could also be a mountainous region that could include formidable mountain ranges and/or gentle hills rolling and unfolding over large tracks of land. The term 'rural' also connotes a distance from the urban centers, a distance which could make a difference to a woman's life. For example, a semi-desert region in Pakistan is connected to the district headquarter by a metal road. In this case, a woman needing emergency obstetric care could access the facility within 90 minutes. However, in this scenario, availability of transport would be determined by the socio-economic class of the family concerned. The very poor would not be able to afford transport to the required facility. Yet, irrespective of class differences, women in villages more than two hours away from a health facility with emergency obstetric care are more likely to become numbers in maternal mortality rates.

Just as rural areas are not a homogenous terrain, there is also a variation in the type of vulnerability to which its residents are exposed. While floods can ravage low lands, and cyclones can play havoc in the coastal belts, earthquakes in the mountain regions present a different set of problems. For example, the October 2005 earthquake in Pakistan brought a unique agony for women. With the entire health infrastructure demolished and all road links scrapped away, women delivered under the open sky, and those with hip injuries/fractures faced additional pain at delivery. In India, lactating rural women who lost their children during the 2004 tsunami suffered from the clotting of milk in their breast.[5] Such geographical realities present formidable challenges to the very idea of SRHR.

The topography of rural areas is not the only source of vulnerability for women's reproductive heath. When these areas become battlegrounds of armed conflicts, vulnerability is exacerbated. It would thus be important to review SRHR in non-conflict situations and under armed conflict. Asia-Pacific countries, such as Bougainville, Cambodia, Nepal, Pakistan, Solomon Islands and Sri Lanka have had internal strifes that have played havoc with the lives of the people, specially the poor. Within that reality, life of women in general, and of pregnant women in particular, becomes more vulnerable to death and disability.[6]

When sexual and reproductive health and rights of rural women are placed within two sets of complexities (those of the concepts within SRHR, and those pertaining to diversity of what is rural), the issue of strategies for SRHR becomes a daunting task. This of course does not mean that efforts have not been made. The issue is how the available efforts are to be analysed so that all strategies gain momentum from available lessons. Ultimately, there is one parameter to begin with and that is the goal towards which the strategies for SRHR are directed. Is the goal to meet some practical needs of rural women, or is it to achieve their strategic interests?[7] Is it to adapt to the available social structures, or to transform them? If one does not deal with these issues critically, one could be proving the saying: "If you don't know where you are going, then any road will do."[8]

However, this saying is belied by all those health advocates who are linked with women's rights groups, or have imbibed rights in their thinking and practice, and are critically aware of the impact of social structure on heath care and health systems, and thereby health outcomes. Their numbers need to grow, and this is possible only when they share their lessons and frustrations so that their approach expands and encompasses all the narrower approaches to health.

Endnotes

1 *It is important to note that not all women's movements are political in nature. Many lobby for changes within the given political structures, while others strive for changes in the overall social structures.*

2 *Here, the reference is to the 1978 definition of health, which is also reflected in the ICPD definition of reproductive health.*

3 *Social determinants are now part of the health discourse, although actions for changing these determinants are often not undertaken within the health sector. Determinants of inequities have yet to come into the health discourse in a meaningful way. At present, these issues appear to be more on the periphery of health discourse, especially in the developing countries.*

4 *Without going into any discussion on the importance of the concepts of 'equity' or 'inequities in health,' suffice it to say that equity is a relative term and thus requires comparison of one group with another. It is also often seen as a normative term, thereby drawing attention to the notion of social justice.*

5 *Burnad, Fatima. 2006. Tsunami Aftermath: Violations of Human Rights of Dalit Women. Tamil Nadu, India & Chiang Mai, Thailand: Asia Pacific Forum on Women, Law and Development. In Rogers, Michelle. 2007. "Rural women's health in Asia: Health status and barriers to access." ARROW. [unpublished briefing paper for the Asian Rural Women's Conference]*

6 *In a district in the province of Punjab, Pakistan, there is a peasant movement for the protection of tenancy rights. At one time, when suppression of the movement by the state became severe, a siege was placed around the villages. A pregnant woman going to a health facility was detained in a police station where she gave birth, and the child died.*

7 *Practical needs are related to women's condition and present workloads or responsibilities and women's immediate needs like health care, education, food and shelter. Strategic needs arise from the analysis of women's subordination to men and is related to changing the position of women vis-à-vis men.*

8 *Caroll, Lewis. 1871. Through the Looking Glass.*

By Kausar S. Khan,
Department of Community Health Sciences, Aga Khan University, Karachi, Pakistan. Email: kausar.skhan@aku.edu

Building Capacities on Evidence-based SRHR Advocacy in Nepal

Nepal, a country with 83% of the population living in rural areas[1] and with 40% living in poverty, is also a country with stark gender inequality. This is reflected in the gender gap in socioeconomic and health indicators, particularly on women's sexual and reproductive health and rights (SRHR). Until recent data came out, Nepal had one of the highest mortality rates in South Asia.[2] Majority of these deaths are attributed to unsafe abortions. Although there is no systematic collection of abortion data, some studies, such as a hospital-based study, revealed that more than a half of the total maternal deaths in hospitals in Nepal were due to unsafe abortions.[3] The 1998 *Maternal Mortality and Morbidity Study* of the Ministry of Health, on the other hand, found that abortion accounted for 10% of maternal mortality. As abortion was illegal in the country until recently, the rate of covert abortions was estimated by a community-based study to be 117 per 1,000 women between 15-49 years.[4]

Through nearly three decades of efforts by different organisations and individuals, abortion was legalised in Nepal in 2002. However, daunting challenges remain in effectively implementing the law, such as: a) socio-cultural and religious challenges of overcoming social stigma and religious restrictions; b) health system challenges (e.g., uneven quality of care and service in Comprehensive Abortion Care or CAC centers, inadequate number of doctors, no separate budget allocation to the safe abortion programme); and c) legal challenges (e.g., no clear legal definition of abortion in law, abortion still dealt under the Homicide Chapter).

It is within this scenario that Beyond Beijing Committee (BBC) began implementing the Women's Health Rights Advocacy Partnership (WHRAP) project in Nepal in 2003. BBC works at local, national and regional levels, ensuring participation of marginalised rural women and focusing on holding duty bearers accountable for fulfilling women's health and wellbeing. At the community level, BBC works with eight local non-government organisations (NGOs) and community-based organisations (CBO) in two districts: Bardiya and Makwanpur. Key WHRAP strategies include: a) conducting baseline research on the SRH situation in project sites and collecting case studies related to abortion and maternal mortality; b) capacity building workshops on research, strategic evidence-based advocacy, media advocacy and health systems monitoring, for local NGOs and CBOs; and c) production of references such as a pictorial Advocacy Tool in Nepali, which uses a rights-based approach and contains key messages on health service provision, safe abortion and safe motherhood. Local evidence is then used to inform strategic planning, as well as local and district-level advocacy and monitoring interventions to key stakeholders, such as health providers, community health workers, community leaders, local media and Village Development Committees. These same rural women's concerns are then brought up to the national level by rural women and CBOs themselves in policy dialogues and other interactions with national SRHR focal points, including representatives from the Ministry of Health, Ministry of Women, National Planning Commission, and others.

Concrete results from advocacy efforts are often difficult to see in a short time. Still, BBC/WHRAP, through its interventions with partner CBOs, has been successful in bringing about some changes. Having gained advocacy skills and knowledge of SRHR issues and government commitments, rural women and CBOs have been empowered. They have spoken up in public meetings and policy dialogues, demanding accessible and free abortion services in primary health posts; they have challenged political parties to commit to including SRHR as a priority area for action in their parties' manifestos in upcoming elections. On the SRH services delivery side, concrete changes include successfully lobbying for the increase in the number of government doctors in the Makwanpur district hospital from one to two, while in Bardiya there are now two doctors whereas before there was none. In addition, the Makwanpur district hospital has increased the number of days wherein they provide safe abortion services from two to six days a week, and has reduced the abortion fee from Nrs. 1200 to Nrs. 1000 (about US$18.90 to US$15.75).

Endnotes

1 *UNFPA. 2007. State of the World Population: Unleashing the Potential of Urban Growth. New York.*

2 *The 2006 Nepal Demographic and Health Survey reports that the MMR has been reduced to 281 out of 100,000 (from 539 out of 100,000 in 1996). The various contributing factors for the decrease, such as conflict and the legalisation of abortion, still needs to be fully understood.*

3 *Thapa, P.J.; Thapa, S.; Shrestha, N. 1992. "A hospital based study of abortion in Nepal." Studies in Family Planning. Vol.23, No.5, pp.311-318.*

4 *Thapa, S.; Thapa, P.J.; Shrestha, N. 1994. "Abortion in Nepal: Emerging insights." Journal of Nepal Medical Association. Vol.32, pp.175-190.*

5 *WHRAP is a regional project to increase the capacity and effectiveness of civil society to advocate for SRHR at the local, national and regional levels. It is being implemented by ARROW and national partners in four countries in South Asia: Bangladesh (BWHC and Naripokkho), India (CHETNA and SAHAYOG), Nepal (BBC) and Pakistan (Shirkat Gah), with support from the Danish Family Planning Association.*

6 *BBC's partners at the grassroots level are Asmita, Nari Sip Srijana Kendra, Youth Welfare Society and HimRights/Hetauda in Makwanpur, and Nepal Red Cross Society/Gulariya, Social Campaign for Integrated Development, Nepal National Depressed Social Welfare Organization, and Bardiya Handicapped Rehabilitation Centre in Bardiya.*

By BBC/WHRAP Team, BBC, Nepal.
Email: beyondbeijing@wlink.com.np

SPOTLIGHT

Rural Women Take Reproductive Health Matters into Their Own Hands

Community level workshops for adolescent girls. Photo by RUWSEC

This paper describes lessons learned about strategies to address rural women's health issues, through the work of Rural Women's Social Education Centre (RUWSEC). Established in the early 1980s in the sub-district of Chengalpattu in Tamil Nadu, India, RUWSEC is a grassroots women's organisation seeking to address women's sexual and reproductive health and rights (SRHR) issues.

I. Guiding principles and strategies. RUWSEC was formed by 12 *dalit* women from different villages in Chengalpattu, Kanchipuram, Tamil Nadu, and by one of the authors of this paper. From their personal experiences as *dalit* women and discussions held with women's groups in many villages emerged the conviction that for women to become agents of social change addressing other issues of oppression, they had to start by dealing with, and transforming, their lack of control over their bodies, and the sense of powerlessness that this led to.[1]

From the very beginning, we saw health and wellbeing as a product of the interaction between social determinants and biological factors. We believed that women would achieve their well-being through informed and collective action at many levels to demand their entitlement to the many determinants of wellbeing.[2] Thus, the local women who founded RUWSEC became 'animators' who set this process in motion in their own hamlets.

The organisation's strategy, which evolved over several years, aimed to bring changes in four areas:[3] women's 'being,' women's 'consciousness,' women's health-seeking behaviour, and the health care system's commitment and ability to meet women's health needs. Since all four areas are intrinsically interconnected, it seemed obvious to us that we needed to work in all four areas. Not only then would we improve women's wellbeing, but also build local women's capabilities to keep up the struggle for their right to health and wellbeing, sustain the gains, and challenge any reversals.

II. Activities corresponding to the strategies. Below, we outline briefly the activities that fall under each of the four areas of action, with examples from RUWSEC's work.

i. Changing women's 'being.' This is how we defined the need to change women's access to resources affecting their health and well-being: poverty, hunger, illiteracy, lack of basic amenities, low wages and back-breaking and hazardous work in agriculture. Activities around this area consisted of mobilising women into groups through regular 'night-meetings' held by local animators in their hamlets, in which women discuss their health problems and factors underlying these. Within the first year, preparing petitions on issues such as the lack of water taps and street lights had become commonplace for the local women's groups. In many villages, there were demands for better wages and/or better working conditions. Over the years, night-meetings became less frequent, but the culture of raising voices collectively and bringing about change through local action was here to stay.

ii. Changing women's 'consciousness.' Raising women's consciousness to question their oppression as women, *dalit* and wage labourers was an important component of RUWSEC's work. This was done as part of the night-meeting discussions and through participatory workshops in which women analysed and questioned the nature of caste, class and gender inequalities in society at the local, national and global levels, and the ways in which this impacted on their lives and wellbeing.[4] Facilitating women's learning about their bodies has been a major part of RUWSEC's work since its inception: women's discussion of gender issues were almost always intertwined

with those of sexual and reproductive rights and domestic violence.

In addition to social and gender analysis and knowledge about SRHR, developing leadership skills was also a part of the agenda for changing women's consciousness. This included skills in public speaking, understanding and using information, dealing with bureaucracy, problem-solving, decision-making and conflict-management. Although only a few women in every hamlet were covered by the leadership training workshops, these skills transformed all women's sense of self worth and worldview. Their confidence to challenge the conditions that oppress them increased significantly.

A few years later, in response to women's demands, we also started working with their husbands and sons. Women needed male allies within the community to transform changed consciousness into concrete changes in gender relations within the household and the community. Men attended workshops that helped them understand the nature of women's subordination, its consequences for women's sexual and reproductive health, and their role as men in altering the situation. Gender-sensitive men became spokespersons in their communities for these issues, and were important allies of RUWSEC in promoting women's wellbeing. When we started a programme for the prevention of domestic violence against women, gender-sensitive men joined women leaders to form violence prevention committees in the local hamlets.

Influencing the consciousness of the younger generation of girls and boys was also an important part of our work. This included a literacy programme for women and several complementary projects on life-skills education for in-school and out-of-school boys and girls, through community, school, work-site and youth centre-based activities. Having a strong gender and rights perspective, the curricula of these programmes aimed to help young people develop into informed, confident, responsible and gender-sensitive adults who were at ease with their bodies and their sexuality.

iii. Changing women's health-seeking behaviour. What we sought to do was multi-pronged: one, we wanted women to feel entitled to care—this happened through changing consciousness; two, we helped them to draw on useful traditional knowledge to initiate self-care at home, or seek simple cures from our animators who were also trained as community health workers. Three, we equipped women with information to identify situations when medical care is necessary; four, we encouraged them to become judicious and discerning users of health care services. Finally, through the mobilisation process, we helped women acquire the means to access health services: e.g., better wages, roads, and bus services; petitioning for the health worker to visit their hamlets; and support from other women in childcare and domestic work.

Data collected by RUWSEC between 1981 and 1999 shows a dramatic increase in institutional deliveries and voluntary use of contraception, as well as a decline in miscarriages and stillbirths.[5] One result of the work we did was increased demand for sexual and reproductive health services, which the existing government health services did not meet. This led to the establishment of RUWSEC's reproductive health services clinic which provides comprehensive reproductive health care services at affordable costs to women from the local villages.

iv. Influencing the health system's commitment and ability to meet women's health needs. During our early years, we tried to improve the delivery of health care services to *dalit* hamlets mainly through representations to authorities and pleas to local health workers. A later project made a systematic attempt to work together with the government and with women leaders of the *panchayats* (local government) to promote the quality of reproductive health services in Primary Health Centres (PHC) in the area. A group of interested *panchayat* women leaders were trained through monthly two-day workshops spread over a period of 18 months, so that they would become knowledgeable about women's health issues and intervene at the PHC level by monitoring quality of care and engaging in creative problem-solving with RUWSEC's workers and PHC functionaries to promote quality of care.

Aside from these actions, RUWSEC has also indirectly contributed to influencing policies and programmes through our many research publications. These publications have given voice to rural *dalit* women's sexual and reproductive health experiences and concerns.

III. Reflections. A lot has changed in Tamil Nadu since 1981. Despite these changes, we believe that the strategy adopted by RUWSEC can still be applied in present times in working to promote rural women's SRHR. One important addition to the strategy would be broad-based networking with like-minded groups to emerge as a major force in setting the SRHR agenda in the region.

Endnotes

1 *Ravindran, T.K.S. 1998. "Rural Women's Social Education Centre, Chengalpattu: Case study of a grassroots organisation working for health promotion through women's empowerment." In Mukhopadhyay, S. (Ed.). Women's Health, Public Policy and Community Action. Delhi, India: Manohar Publications.*

2 *We did not have the language of rights at that time, but our approach is what one would now term as a rights-based approach.*

3 *Ravindran, T.K.S. 1989. "Rural women's health status: Towards a framework for analysis and action." Women's Global Network for Reproductive Rights Newsletter. pp. 32-35.*

4 *Ravindran, T.K.S. 1989. "Subverting patriarchy: Workshops for rural women." Chengalpattu, India: Rural Women's Social Education Centre.*

5 *Ravindran, T.K.S. 1995. "Women's health in a rural poor population in Tamil Nadu." In Das Gupta, M.; Chen, L.C.; Krishnan, T.N. (Eds). Women's Health in India: Risk and Vulnerability. Bombay, India: Oxford University Press.*

By T.K. Sundari Ravindran (Co-Founder) and
P. Balasubramanian (Executive Director), RUWSEC.
Emails: ravindrans@usa.net & kcm_rural@sancharnet.in

International

Rural women's health was one of main issues tackled at the *Fourth World Congress of Rural Women*, which was held in Durban, South Africa from 21-26 April 2007. The World Congress is an international gathering of rural women, occuring at four-year intervals, which has been hosted previously by Australia in 1994, the USA in 1998 and Spain in 2002. With the theme "United in Our Diversity: Working Together Towards the Total Emancipation of Rural Women from Poverty and Hunger," the 4th Congress aimed to discuss universal and wide-ranging issues confronting rural women and to share concrete experiences of successes in addressing these. These issues included globalisation and trade; sustainable development; gender equality; food security and related issues of access to land, water, finance, new technologies, transport and roads; rural housing; governance; the impact of public policies on rural women; and women's health.

A "Declaration of the Fourth World Congress of Rural Women" was issued at the end of the meeting, affirming full commitment to the realisation of the aspirations of rural women as reflected in Beijing Platform of Action. The Declaration recognised that rural women still have less access to land, natural resources, infrastructure, financial and information and communication technologies; and that globalisation further exacerbates the marginalisation of rural women in accessing opportunities, wealth and resources. They also noted with concern the continuing rise in the number of rural women living in poverty, resulting from economic challenges faced by many developing countries, which in turn are the result of inequities in trading regimes between the developed and developing countries. The Declaration also recognised that water and health are pillars of development. Participants called upon national governments, international and intergovernmental organisations, civil society and the corporate sector to take collective responsibility to work in partnership with rural women organisations towards recommendations that will improve rural women's situation. Health-related measures included increasing investments in the generation of data to understand the nature and impact of HIV/AIDS on rural women's livelihoods and coping strategies; strengthening partnerships to eradicate diseases such as HIV/AIDS, tuberculosis, malaria and other diseases; and ensuring availability of primary heath care to women in rural areas.

Some 2,000 local and international delegates participated in the congress. Delegates were drawn from rural women themselves, government, civil society, international and intergovernmental organisations, NGOs and community-based organisations.

Source: www.4thworldcongressofruralwomen.co.za

Regional

On 31 July–2 August 2007, 52 Asian rural women, along with representatives from national movements and regional NGOs working on Asian rural women's issues, came together in Manila, Philippines for the *Asian Rural Women's Regional Consultation*. The consultation was a landmark event hosted by the *Asian Rural Women's Conference* (AWRC) Steering Committee consisting of Tamil Nadu Women's Forum India, Human Development Organisation Sri Lanka, All-Nepal Women's Alliance, Gabriela Philippines, Tenaganita Malaysia, Committee for Asian Women (CAW), Asia-Pacific Resource and Research Centre for Women (ARROW), Asia-Pacific Forum on Women, Law and Development (APWLD), International Movement Against All Forms of Discrimination (IMADR) and Pesticide Action Network Asia Pacific (PAN AP). This meeting aimed to strengthen Asian rural women's movements, as they looked at ways to forge links among peasant, indigenous, agricultural workers, *dalit* women, workers and migrants movements.

Simultaneous workshops were conducted, enriching the experiences and analyses of rural women's issues and perspectives. A press conference was also held, highlighting issues of rural women in Asia and making assertions against globalisation's impact on rural women's lives and livelihood. This consultation process provided a venue to expand the space for rural women's voices to be heard, and was at the same time a stepping-stone towards the AWRC in 2008.

As a result of the regional consultation, a "Rural Women's Declaration on Rights, Empowerment and Liberation" (dubbed as the "Manila Declaration") was created. The "Manila Declaration" demanded and asserted rural women's rights to self determination, secure livelihoods, land and productive resources, just wages, health, food sovereignty and democracy. Significantly, the Declaration was crafted collectively by various rural women sectors hoping to serve as a reminder to continuously strengthen movements and consolidate voices for economic, social, cultural and political changes at the local, national and global levels.

Source: Marjo Busto Quinto, Programme Development Officer, Pesticide Action Network Asia Pacific, Penang, Malaysia. Tel.: +604-6570271 /6560381. Fax.: +604-6583960. Email: panap@panap.net

The United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) organised the "Expert Group Meeting on Emerging Issues in Rural Poverty Reduction: The Role of Participatory Approaches," on 6-7 November 2007 at the United Nations Conference Centre (UNCC) in Bangkok, Thailand. The objective of

the meeting was to exchange ideas and experiences on the role of participatory approaches in rural poverty reduction. Issues discussed included typologies of participation and their suitability for different situations; decentralisation, participatory development and poverty; the importance of social, economic and political context; and challenges of scaling up and participatory governance.

The meeting was attended by 20 experts from 11 countries as well as by representatives of the Food and Agriculture Organization of the United Nations (FAO) and the Centre for Alleviation of Povery through Secondary Crops' Development in Asia and Pacific (CAPSA). Participants identified a number of issues requiring further research and advocacy: inclusion of marginalised groups in government development policies starting at the planning stages; partnerships with local governments to promote participatory approaches; refinement of tools such as PAR (Participatory Action Research) and CVT (Community Voice Tool) to allow for more equitable representation of different individuals within a small community; methodologies for participatory approaches to take into account existing power relations in the community; effective ways of replicating and upscaling participatory micro-initiatives; and the role of the government in scaling-up successful initiatives. The meeting also stressed the need to develop new and innovative ways of taking into account the special needs of women and their role in rural community initiatives.

Source: Jorge Carrillo, Human Settlements Officer, Poverty Reduction Section Poverty & Development Division, United Nations ESCAP, Bangkok Thailand. Tel.: +66-22881613. Email: carrillo.unescap@un.org

Sri Lanka

A two-day ***National Consultation on Rural and Indigenous Women's Liberation*** was organised by the Women's Watch of the Human Development Organization (HDO) with the collaboration of IMADR Asia Committee at Kandy, Sri Lanka, on 11-12 July 2007. Around 50 women participated from different parts of the country, sectors and organisations. The national consultation process was carried out to facilitate sharing of experiences and perspective building. It was meant to ensure that rural women's voices and various strategies of resistance on the ground are heard and represented. Discussions and recommendations culled from the national processes were echoed at the regional consultation and will be reflected at the *Asian Rural Women's Conference* in 2008.

Similar national consultations were conducted in India and in the Philippines.

Source: www.asianruralwomen.net/html

UPCOMING

The "Rights, Empowerment and Liberation: Asian Rural Women's Conference," which is hosted by the Tamil Nadu Women's Forum (TNWF), the Tamil Nadu Dalit Women's Forum (TNDWF) and the Society of Rural Development (SRED), will take place on a vast field in Arakonam, Tamil Nadu, India from 6-8 March 2008. More than a thousand rural and indigenous women from various sectors of peasants, agricultural workers, fisherfolk, *dalits*, pastoralists, informal workers, child labourers and minorities all over Asia are expected to take part in this conference. Women's organisations, regional networks, public interest groups and support NGOs are also supporting the activities.

The conference aims to strengthen the rural and indigenous women's movement and to build the leadership of women from peasant, indigenous, workers, *dalit*, fisherfolk, migrants and pastoralist movements, among others. It hopes to provide a venue for building perspectives and a process to evolve and to create unity and solidarity among women and with other movements. It is also an attempt to develop new visions and new thinking about feminism, liberation, emancipation and the women's perspective on national liberation and food sovereignty. It is hoped that it would be a venue to discuss, to debate, to brainstorm and to strengthen perspectives, strategies and collective action.

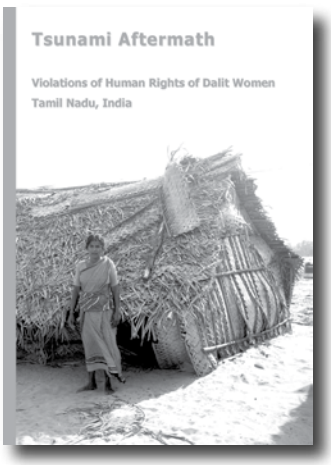
While the main theme of the conference is "Rights, Empowerment and Liberation," eight focal themes will be covered by the conference. Based on issues, experiences and perspectives of rural and indigenous women in Asia, these themes are "Rural Women in the Era of Globalisation," "Women Workers: Labour and Trade," "Land, Livelihood and Resources," "Migration, Displacement and Trafficking," "Indigenous Women," "State Terrorism and Militarisation," "Disempowerment of Women," "Women's Movement in Asia" and "Women's Health" (including Sexual and Reproductive Health and Rights). Briefing papers on the themes have been prepared to spark discussion and debate and are available at the conference website. (ARROW prepared the briefing paper on "Women's Health.")

During the three-day event, there will be speak-outs and testimonies from rural and indigenous women sectors in Asia, symposiums and forums on rural women's issues, an organic food festival, film and other cultural presentations from various countries and other solidarity actions. Culminating on International Women's Day, the conference will be followed by a two-hour women's caravan led by rural and indigenous women weaving through streets and fields and a public assembly of 10,000 grassroots women leaders.

Source: www.asianruralwomen.net/html

Balakrishnan, Revathi. 2005. *Rural Women and Food Security in Asia and the Pacific: Prospects and Paradoxes.* Bangkok, Thailand: Food and Agriculture Organization (FAO). 105p. Available at www.fao.org/docrep/008/af348e/af348e00.htm Tel.: +66-2-6974000. Fax.: +66-2-6974445.

This thorough report provides an overview of rural women's considerable economic and social contributions in Asia and the Pacific, particularly in food and agricultural production, and in guaranteeing food security and wellbeing for households. It also discusses the persisting barriers to rural women's development, including the lack of awareness and appreciation for their roles and contributions, continuing gaps in gender equality which contrasts with gains among women in urban setting, inequity in access to resources and opportunities, as well as global and regional trends affecting their situation. To improve these conditions, the author emphasises the need to improve the collection and analysis of sex-disaggregated data in the agriculture and rural production sectors; improve the gender planning capacities of national agencies; pursue interventions on valuation of unpaid work; empower rural women through education and access to information and technology; improve rural women's access to basic services; and undertake studies to assess the impact of regional trends in economic integration, emerging technologies, HIV/AIDS and natural disasters.



Burnad, Fatima. 2006. *Tsunami Aftermath: Violations of Human Rights of Dalit Women, Tamil Nadu, India.* Chiangmai, Thailand: Asia Pacific Forum on Women, Law and Development (APWLD) & Society for Rural Education and Development (SRED). 42p. Available at www.apwld.org/pdf/Tsunami_India.pdf Tel.: +66-53-284527. Fax.: +66-53-280847.

Based on a survey of women's rights violations in India in the aftermath of the 2004 tsunami, this report revealed that although many may think that everyone is equally affected when disasters strike, women and children are disproportionally affected. Not only did 80% of the deaths occur in women, women experienced cruel acts depriving them of their human rights, such as forced recanalisation and tsunami marriages which were promoted through financial incentives from the government. The report also identified inadequate and unfair post-tsunami relief efforts by the government and NGOs, and showed the impact it made on the lives of *dalit* women. The final part of the report is devoted to gender-sensitive disaster management, with recommendations on standards such as adequate food and clothing, access to health services, security and freedom from violence, and right to participate in decision making processes of those who are affected by disasters. APWLD has also produced reports on the tsunami aftermath in Indonesia, Thailand and Sri Lanka.

George, A. 2007. "Persistence of high maternal mortality in Koppal district, Karnataka, India: Observed service delivery constraints." *Reproductive Health Matters.* Vol.15, No.30, pp.91-102. Tel.: +44-0-20-7267-6567. Fax.: +44-0-20-7267-2551. Email: ashasara@gmail.com

This paper discusses the service delivery constraints that contribute to high levels of maternal mortality in Koppal, the poorest region in the state of Karnataka, south India. The research is based on a collaborative study through the Gender and Health Equity Project led by Gita Sen of the Indian Institute of Management Bangalore (IIMB), the Karnataka Health and Family Welfare Department, and Mahila Samakhya Karnataka (MSK)—a women's empowerment programme that promotes women's right to health in 60 villages. Despite the number of women in the region who seek medical treatment, many of them die from obstetric complications, due to weak information systems that fail to document maternal deaths, the lack of continuity in care from antenatal care to delivery, unskilled health care workers, haphazard referral systems, and distorted accountability mechanisms. Although new budget allocations are in place, the author commented on the lack of engagement with informal providers and the service delivery constraints being ignored, and emphasised that managerial change must occur to save women's lives.

Iyer, A.; Sen, G.; George, A. 2005. "Entitlements to health care in rural Karnataka (India): Interweaving webs of power." Paper presented at the *Global Forum for Health ResearchForum 9*, Mumbai, India, 12-16 September 2005. 20p. Available at www.globalforumhealth.org/filesupld/forum9/CD%20Forum%209/papers/Iyer%20A.pdf Tel.: +41-22-7914260. Fax.: +41-22-7914394.

The reality of being stricken with poverty and illness with little ability to access health care is becoming more common in countries with market-oriented health sectors. Medical expenditures is one of the three most important drivers of poverty in the world. In this paper, the authors describe the intersections and interactions between gender, class, and life stage and explore the ways in which these factors define entitlements to health care in conjunction with the notion of sickness severity. The research, which is based in one of the poorest regions in Karnataka with more than 80% rural population, saw that the poor and disempowered

had the greatest health needs but were also the first ones to be excluded from health care. It also found that males enjoy better access to health care for short-term sicknesses regardless of whether they or their wife was the head of the household.

Kariapper, Reihana. 2007. *Reproductive Health and Rights: Unravelling Realities.* Lahore, Pakistan: Shirkat Gah. 66p. Tel.: +92-21-5831140/0563. Email: shirkat@cyber.net.pk, sgah@sgah.org.pk

The stories of Kaneez who has only one child living from seven pregnancies, and Salma who miscarried due to the negligence of family members, are just two of the 55 case studies presented in this valuable publication. These cases from Shirkat Gah's community research in Punjab and Sindh are rich empirical evidence of the various issues surrounding women's SRHR in Pakistan. The report also provides a situationer on Pakistan and an analysis of the case studies. It concludes by giving recommendations for improvement, including giving refresher trainings for *dais* or traditional birth attendants (most normal deliveries are conducted at home and *dais* are the only health providers available in terms of emergency); putting in place a monitoring mechanism for *dais*; providing reproductive health and rights sessions at the household level; instituting a strong referral system to link communities to local health providers and health facilities; and mobilisation of communities to demand accountability from government officials and improve health services.

Kaufman, Joan. 2005. "China: The intersections between poverty, health inequity, reproductive health and HIV/AIDS." *Development.* Vol.48, No.4, pp.113–119. Available at www.palgrave-journals.com/development/journal/v48/n4/full/1100187a.html Tel.: +44-1256-329242. Fax.: +44-1256-810526.

This article discusses the impact of China's health reforms from the 1970s to the 1990s on women's health. China's primary health care, which was recognised as a WHO model in 1978, has deteriorated within the next two decades due to the country's shift to market economy. This was accompanied by a decrease in public financing of health care, widening gap in government health investments that strengthened the urban health system at the cost of the rural, and the decline of public health education and prevention outreach. With family planning services undertaken and separately funded by the National Population and Family Planning Commission, maternal and child health care suffered another strike, creating a paradoxical situation where a strongly funded population policy reduced pregnancies and maternal-related risks even though women's access to reproductive services through health care continued to decline, and which was compounded by women's increased rate of RTIs and HIV/AIDS. The author contends that China's rural health reform—which recently focuses on the 'for profit' hospital system—does not show any signs of promise in overcoming obstacles in women's health.

Khan, Kausar. 2006. "Social determinants of health in Pakistan: The glass is more than half empty." [draft] World Health Organization. 30p. Available at gis.emro.who.int/HealthSystemObservatory/PDF/Social%20determinants%20of%20heatlh/Pakistan.pdf

This paper gives an overview of the health sector in Pakistan and social determinants of health, and discusses health policies and reforms pertaining to women and gender. Though indicators on many social determinants of health are available (i.e., literacy, income, locality, gender, birth control) there is a need to expand the domains, as many relevant ones are not being considered. The author suggested analysing domains such as transport, livelihood, food security, and gender as power relations and linking them to health outcomes. In addition, there is a need to go beyond viewing differences in health outcomes as sectoral issues, and to unveil the underlying processes and causes of inequality at societal and structural levels, beginning with the addressing of power relations.

Sen, G.; Piroska, O.; George, A. 2007. *Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why It Exists and How We Can Change It: Final Report to the WHO Commission on Social Determinants of Health.* Women and Gender Equity Knowledge Network. 145p. Available at www.eurohealth.ie/pdf/WGEKN_FINAL_REPORT.pdf

This report combines an extensive review of scientific literature, research articles, policy reviews and evaluations, case studies, and 'grey' literature, with a series of recommendations based on research. The authors discuss the nature of gender inequality, and its manifestations from norms, values and practices, gender differences in health risk exposure and vulnerability, and the politics behind health care systems, to the content and process of health research. The report recommends seven strategies to move forward: address the essential structural dimensions of gender inequality; challenge gender stereotypes and adopt multilevel strategies to change norms and practices that directly harm women's health; reduce health risks by tackling gendered exposures and vulnerabilities; transform the gendered politics of health systems; take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research; take action to make organisations at all levels function more effectively to mainstream gender equality; and support women's organisations who are critical in ensuring that women have voice and agency.

Other Resources

Aalochana Centre for Documentation and Research on Women. 2008. *Redefining Politics: Women in Local Self Government: Calendar for 2008.* [with accompanying booklet]. Pune, India: Aalochana. Tel.: +91-020-25444122. Email: alochanapune@gmail.com

Baer, Adela. 2006. "The health of Orang Asli Women." In Baer, A. et al. *Orang Asli Women of Malaysia: Perceptions, Situations & Aspirations*. Petaling Jaya, Malaysia: Center for Orang Asli Concerns. 168p. Tel.: +603-79578343. Fax.: +603-79549202 Email: gerakbudaya@pd.jaring.my

Barker, C.E. [et al.] 2007. "Support to the Safe Motherhood Programme in Nepal: An integrated approach." *Reproductive Health Matters.* Vol.15, No.30, pp.81–90. Email: cherry@ssmp.org.np

Chandy, H. [et al.] 2008. "Comparing two survey methods for estimating maternal and perinatal mortality in rural Cambodia." *Women and Birth.* [Article in press]. Email: tmc@unn.no

D'Ambruoso, L. [et al.] 2008. "Assessing quality of care provided by Indonesian village midwives with a confidential enquiry." *Midwifery.* [Article in press]. Email: l.dambruoso@abdn.ac.uk

Global Forum for Health Research. 2007. *Equitable Access: Research Challenges for Health in Developing Countries; Global Forum Update on Research for Health Volume 4.* 180p. Available at www.globalforumhealth.org

Institute for Social Studies and Action (ISSA). 2007. *Blazing the Trail for Monitoring MDG5: Target 7 in La Union—A Pilot Project.* Quezon City, Philippines: ISSA. 128p. Telefax: +632-410-1685. Email: issa1183@gmail.com

Lan, P.T. [et al.] 2007. "Perceptions and attitudes in relation to reproductive tract infections including sexually transmitted infections in rural Vietnam: A qualitative study." *Health Policy.* [Article in press]. Email: landhy2003@yahoo.com

Rengam, S. [et al.] [n.d.]. *Resisting Poisons, Reclaiming Lives: Impact of Pesticides on Women's Health.* Penang, Malaysia: Pesticide Action Network Asia and Pacific (PAN AP). Tel.: +604-6570271. Fax.: +604-6583960. E-mail: panap@panap.net

Schulera, S.R. [et al.] 2006. "The timing of marriage and childbearing among rural families in Bangladesh: Choosing between competing risks." *Social Science & Medicine.* Vol.62, pp.2826–2837. Email: sschuler@aed.org

ARROW's Publications

ARROW. 2007. *Rights and Realities: Monitoring Reports on the Status of Indonesian Women's Sexual and Reproductive Health and Rights; Findings from the Indonesian Reproductive Health and Rights Monitoring & Advocacy (IRRMA) Project.* Kuala Lumpur, Malaysia: ARROW. 216p. Price: US$10.00

ARROW. 2005. *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015, Asian Country Reports.* Kuala Lumpur, Malaysia: ARROW. 384p. Price: US$10.00

ARROW, Center for Reproductive Rights (CRR). 2005. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia.* New York, U.S.A.: CRR. 235p. Price: US$10.00

ARROW. 2003. *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research.* Kuala Lumpur, Malaysia: ARROW. 147p. Price: US$10.00

ARROW. 2001. *Women's Health Needs and Rights in Southeast Asia: A Beijing Monitoring Report.* Kuala Lumpur, Malaysia: ARROW. 39p. Price: US$10.00

Abdullah, Rashidah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing.* Kuala Lumpur, Malaysia: ARROW. 30p. Price: US$10.00

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1–4 June 1998, Kuala Lumpur, Malaysia.* Kuala Lumpur, Malaysia: ARROW. 65p. Price: US$10.00

ARROW. 1999. *Taking up the Cairo Challenge: Country Studies in Asia-Pacific.* Kuala Lumpur, Malaysia: ARROW. 288p. Price: US$10.00

ARROW. 1997. *Gender and Women's Health: Information Package No. 2.* Kuala Lumpur, Malaysia: ARROW. v.p. Price: US$10.00

ARROW.1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific; Health Resource Kit.* Kuala Lumpur, Malaysia: ARROW. v.p. Differential Pricing.

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* Kuala Lumpur, Malaysia: ARROW. v.p. Price: US$10.00

Payments accepted in bank draft form. Please add US$3.00 for postal charge. For more details, email arrow@arrow.po.my

Definitions

Health equity

"Health equity is the absence of disadvantage to individuals and communities in health outcomes, access to health care, and quality of healthcare regardless of one's race, gender, nationality, age, ethnicity, religion, sexual orientation, immigration status, language skills, health status and socioeconomic status."[1] Inequities due to site (urban-rural) also need to be highlighted and addressed to achieve health equity. Using an equity approach as opposed to a poverty one means that governments would not just "see the poor as a marginal group which needs special attention," and thus build two different health systems, "whereby there will be talk of safety nets and mechanisms for reaching the poor." Rather, governments "would strive to build one system which would be fair, as [they] monitor inequities and strive to reduce them."[2]

Gendered structural determinants of health

Gendered structural determinants of health are critical factors that shape people's health. They are constituted by the following:

- **gender**, as a system of power and stratification which places women (and also trans and intersex people) in a subordinate position to men as shown by various examples of gender inequalities and inequities, and its intersections with other bases of discrimination and bias (e.g., economic class, race or caste);
- **structural processes**, such as rising literacy and education, demographic transitions in birth and death rates and in family structures and globalisation (including its effects on labour forces, health systems and the media), and the strengthening of human rights discourse, and
- **the interactions** between these.

These are then linked to **intermediary factors**—discriminatory values, norms, practices and behaviours; differential exposures and vulnerabilities to disease, disability and injuries; biases in health systems; and biased health research. These intermediary factors in turn result in biased and inequitable health outcomes, which can then have serious economic and social consequences for girls and boys, women and men, for their families and communities, and for their countries.[3]

Rural women

Rural women, according to the organisers of the Asian Rural Women's Conference 2008 (ARWC), include women peasants, *dalits*, fisherfolk, indigenous women, agricultural workers, child labourers, consumers, pastoralists, migrant and informal workers and minorities, among others. While women's experiences in various communities are very diverse, there is a common thread among rural women's issues—rural women are "subjugated by cultural, social and patriarchal norms that have become institutionalised," and are "caught in a web of exploitation." They face "inequities based on gender [which] are rooted in organised oppression through class, caste, race and ethnicity," among other factors. Yet rural women are not victims, but agents of change as they "struggle for rights, identity, dignity, empowerment and full potentiality."[4]

Endnotes

1 *South Asian Health Project, www.southasianhealth.org/healthequity.aspx*
2 *Khan, Kausar. 2006. See entry in Resources section.*
3 *Sen, G.; Piroska, O.; George, A. 2007. See entry in Resources section.*
4 *Asian Rural Women's Conference 2008 Background, www.asianruralwomen.net*

Editorial Team
Saira Shameem, Executive Director
Sivananthi Thanenthiran, Programme Manager
Rodelyn Marte, Programme Manager
Maria Melinda Ando, Programme Officer & Managing Editor of AFC
Michelle Rogers, Programme Officer
Sai Jyothirmai Racherla, Programme Officer
Jenny Acton, Programme Officer
Felicity Sims, Assistant Programme Officer
Amy Yeung, Intern, Annotator
M.R. Print, Designer & Printer

Expert External Readers
Aditi Iyer, Indian Institute of Management Bangalore Research Consultant
Bina Pradhan, Gender Specialist, Nepal & WHRAP South Asia Regional Task Force Member

Special thanks to the ff. Programme Advisory Committee members for helping in conceptualising the issue:
Aruna Uprety & Ranjani Krishnamurthy

***ARROWs For Change (AFC)** is produced tri-annually and is primarily for Asian-Pacific women's organisations and decision-makers in health, population and reproductive health. The bulletin is developed with input from key individuals and organisations in the Asia-Pacific region and ARROW's Information and Documentation Centre. Articles in AFC may be reproduced and/or translated without prior permission, provided that credit is given and a copy of the reprint is sent to the Editors.*

AFC receives funding support from Oxfam Novib and the Swedish International Development Cooperation Agency (Sida).

Feedback and written contributions, especially for the Resources and Monitoring Country Activities sections, are welcome. Please send them via e-mail to: **afc@arrow.po.my** or by mail to:

Asian-Pacific Resource & Research Centre for Women (ARROW)
No. 80 & 82, 3rd Floor, Jalan Tun Sambanthan
Brickfields, 50470, Kuala Lumpur, Malaysia
Tel: +603-2273-9913. Fax: +603-2273-9916.
Website: www.arrow.org.my

This AFC volume is also available in Tamil. Translated and produced by the Rural Women's Social Education Centre (RUWSEC), Tamil Nadu, India, and published by ARROW.

DEFINITIONS

Health for All? Examining the Rural-Urban Access Divide

The divide between rural and urban women's access to sexual and reproductive (SRH) health services in Asia is considerable. This is an issue that demands critical inquiry, as much of Asia live in rural areas (e.g., Nepal 83%, Cambodia 79%, Bangladesh 74%, India 71%, China 58%, Indonesia 50% and the Philippines 36%).[1] Examining this divide provides an entry point into looking at the various causal factors that limit access. It should be noted from the outset, though, that inequities that arise from the diversity among rural women (e.g., class, race, ethnicity, caste, age, education, poverty, employment and sexual preference) and of rural communities (e.g., geography, topography, resources and experiences of conflict and disaster)[2] also impact accessibility.

Health indicators, such as assistance during delivery from a trained health professional, unmet need for family planning and knowledge of HIV prevention methods, expose the inequities between rural and urban women's SRH access.[3] Rural women are less likely than urban women to have professional assistance during birth: Bangladesh (11.1% vs. 33.8%); Cambodia (42.3% vs. 73.7%); Indonesia (57.3% vs. 81.3%); Nepal (21% vs. 54.2%); and the Philippines (41.2% vs. 80.2%).[4] Rural women also report greater unmet need for family planning compared to urban women: Bangladesh (11.6% vs. 9.2%); Cambodia (25.7% vs. 21.8%); Nepal (25.5% vs. 19.8%); and the Philippines (19.7% vs. 15.3%).[4] Finally, fewer rural than urban women can correctly identify two HIV prevention methods: Nepal (52% vs. 71%); Cambodia (79% vs. 86%); Indonesia (12% vs. 28%); and the Philippines (43% vs. 46%).[4]

As the table below suggests, rural women, more than their urban counterparts, struggle to access health care. They report more problems with barriers such as cost, geography, transportation, lack of information on where to access services, getting permission, concern about there being a female provider, and/or not wanting to visit the health facility alone.[4,5]

Problems Reported by Rural and Urban Women in Accessing Health Care[4,5]

	Country	Bangladesh (2004)	Cambodia (2005)	Indonesia (2002/2003)	Nepal (2006)	Philippines (2003)
Not knowing where to go for treatment (%)	Rural	10.5	-	5.7	-	20.2
	Urban	6.5	-	3.1	-	11.1
Getting money for treatment (%)	Rural	15.7	77.2	30.1	40.0	74.9
	Urban	8.2	59.3	16.0	32.2	62.0
Distance to health facility (%)	Rural	9.3	42.3	18.5	45.2	40.9
	Urban	5.0	21.9	5.1	15.0	17.1
Having to take transport (%)	Rural	13.5	41.6	17.5	44.0	38.6
	Urban	8.6	25.1	4.3	12.2	16.0
Getting permission to go for treatment (%)	Rural	18.8	14.5	5.5	6.9	14.7
	Urban	12.8	13.4	2.7	7.2	7.8
Not wanting to go alone (%)	Rural	20.5	46.1	10.8	57.0	34.2
	Urban	14.3	39.5	6.0	39.8	23.6
Concern there may not be a female provider (%)	Rural	18.5	37.2	6.8	52.0	24.8
	Urban	3.7	35.4	4.4	41.6	17.5

These indicators reference deeper causal factors that restrict rural women's SRH access. On the demand side, barriers that may be particularly problematic in poor, conservative rural communities include social processes and gender norms that may prevent the acknowledgement of women's special health needs, and affect women's agency and mobility.[6,7,8,9] Moreover, inadequate health knowledge causes ineffective or delayed treatment seeking.[9] On the supply side, major barriers are governments' failure to prioritise the funding and development of rural health systems, and the marginalisation of SRH services (as driven by health sector reforms).[9,10] Rural areas thus frequently lack adequate SRH supplies, facilities, technical expertise and human resources.[7,8] Ineffective information and referral systems, discontinuity of care, distorted accountability mechanisms and other service delivery constraints pose additional barriers.[8,11] The absence of female providers and gender-insensitive and uncaring attitudes of providers likewise increase reluctance to seek services.[8]

Where do we go from here? Strengthening the evidence base is critical to understand the issues and inform appropriate policy and programme changes. This involves revising how national research is done (only the most recent demographic and health surveys or DHS have looked into this divide).[12] Analysis of *why* certain barriers are more significant than others in a particular country or locale or among different groups of women—which the current DHS lack—is also needed to better understand the context in which inequities arise and persist. Finally, women-centred action research must be done to provide for rural women's involvement. Only then will rural women's perspectives, needs and concerns be fully considered within a process that sees change as an immediate outcome of the research.

Endnotes

1 *UNFPA. 2007. State of the World Population: Unleashing the Potential of Urban Growth. New York: UNFPA.*
2 *See editorial of this ARROWs For Change issue.*
3 *WHO; UNFPA. 2005. Measuring Access to Reproductive Health Services: Report of WHO/UNFPA Technical Consultation, 2–3 December 2003. Geneva: WHO.*
4 *Latest demographic and health surveys (Bangladesh 2004, Nepal 2006, Cambodia 2005, Indonesia 2002–2003, and Philippines 2003). www.measuredhs.com*
5 *The survey respondents (women aged 15–49) could cite more than one problem.*
6 *Iyer, A.; Sen, G.; George, A. 2005. "IDS Working Paper 253: Gendered health systems biased against maternal survival: Preliminary findings from Koppal, Karnataka, India." Brighton: IDS.*
7 *"Factors affecting access." www.eldis.org/go/topics/resource-guides/health/key-issues/universal-access-to-sexual-and-reproductive-health-services/factors-affecting-access*
8 *Afsana, K.; Rashid, S.F. 2003. "A women-centred analysis of birthing care in a rural health centre in Bangladesh." In ARROW. Access to Quality Gender-Sensitive Health Services: Women-centred Action Research . pp.43–60.*
9 *Correspondence with Aditi Iyer, 8 February 2008.*
10 *Fang Jing. 2004. "Health sector reform and reproductive health services in poor rural China." Health Policy and Planning. Vol.19 (Suppl.1), pp.i40–i49.*
11 *George, Asha. 2007. "Persistence of high maternal mortality in Koppal District, Karnataka, India: Observed service delivery constraints." Reproductive Health Matters. Vol.15, No.30, pp.91–102.*
12 *Only in five countries out of 10 where DHS are conducted in South and Southeast Asia.*

By Michelle Rogers, Programme Officer, ARROW.
Emails: arrow@arrow.po.my, michrogers2000@hotmail.com