ACCESS TO WOMEN HEALTH CARE THROUGH LIBERTY

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ABSTRACT

In low income countries problems of access concern the availability of basic health services. In affluent countries where basic service was generally accessible, question of access concern the degree of comprehensive that can be offered by health care system. Access to health care is a "basic human right and social goal in the sense that all individuals are consider to be entitled of economics benefits of the wider community does not necessary require that they should receive it". Health infrastructures of India are far from requirements and the outcomes of health are far from satisfactory. This is because of, both, inadequate health care facilities to the population as well as due to insufficient affordable capacity of majority of the people. Gender discrimination in health sector is more in rural poor household cases. "Healthy Women is Healthy World". In case of women patient there delay of treatment and expenditure also low. Access to women health care concern, but there are not affordable. Because poor people are unable to afford for a better health care services. For access, affordable and availability of women health care need women awareness through education. Because access to women health care not only concern on women, but also for child health care. Female mortality rate is also high compare to male. This ratio is high among poor tribal women. This study examine the access to women health care, its affordability, equity, physical access of health care facilities in terms of provision of health infrastructure and allocation of resources for health care system, outcomes and its implication. The study is also base on theoretical prospect and some secondary level data have been used to finding of this study.

Key Word: Accessibility, Avaibility, Affordability, Liberty, Women, Healthcare.

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INTRODUCATION

Restructuring does not just relate to the material but also relates to identity and many more socioeconomic phenomenons. The term global restructuring has been used in a variety of ways to mean very different things. But central to all these accounts is a dramatic increase in economic, social and cultural interdependence between countries (Giddens, 1990, Lechner and Boli 2000). This has been accompanied by a greater concentration of power in the richest parts of the world and a reduction in the capacity of some nation states to respond effectively to the needs of their citizens. In recent decade has seen increasing debate about the impact of globalization or global restructuring on human health. There are many attempts have been made to assess the impact of these global trends on the health of populations (Dollar, 2001, Weisbrot et al. 2001).

The following analysis of access to women health trough liberty starts with the right to be free from all forms of discrimination and then addresses rights to survival, liberty and security of the person, the right to family and private life, rights regarding information and education, the right to health and health care, the right to the benefits of scientific progress and the rights regarding women's empowerment. Examples are given of how each of these rights has been or could be applied to women's health problems. These rights may be applied differently in each country depending on the pattern of health services, the evolving understanding of health issues and perceptions of how women's ill-health can be prevented and treated in cost-effective ways.

WOMEN AND HUMAN RIGHT

Women's health interests often cross the boundaries that separate one legally described right from another. Advocates tend to invoke several rights that they allege have been jointly violated. They identify the specific articles of conventions that contain particular rights, and tribunals will distinguish one right from another in their judgements. However, approaches to women's health must refer to all of the several rights often implicated in a particular grievance.

The right of women to be free from all forms of discrimination

The Women's Convention characterizes women's inferior status and oppression not just as a problem of inequality between men and women but rather as a function of sex and gender discrimination against women. The Convention is intended to be effective in liberating women to realize their individual and collective potential, and not merely to allow women to be brought to the same level of protection of rights that men enjoy. The Convention goes

beyond the goal of non-discrimination between sexes, as required by the United Nations Charter, the Universal Declaration and its two implementing Covenants, and the three regional human rights treaties, to address the disadvantaged position of women in all areas of their lives, including health. It recognizes that women are subject not only to specific, obvious inequalities but also to pervasive and subtle forms of sex and gender discrimination that are woven into the political, cultural and religious fabric of their societies. In addressing "all forms" of discrimination that women suffer, the Women's Convention requires States to confront the social causes of women's inequality in all systems, including the health system.

Now a day States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Laws governing women's health should be scrutinized to ensure that they do not discriminate against women, by, for example, perpetuating negative or trivializing sex-role stereotypes that prevent women from being treated on their merits. Liability to pregnancy distinguishes women from men on biological grounds. Pregnancy-related disadvantages, such as exclusion from education, public office or employment (except when non-pregnancy is a bona fide work-related requirement), may accordingly be shown as illegally discriminatory against women because only women will suffer those disadvantages. Laws that deny or restrict women's access to health services or make access dependent on another's authorization impair women's rights. Such laws also impair women's power to protect their lives and health and to found families of a size and structure that best protect their health and that of their families. Laws restricting health services in this way can have a disadvantageous impact on women as opposed to men and can thereby constitute discrimination against women.

Some countries that have ratified the Women's Convention have moved to give effect to the Convention in domestic law. The Colombian Ministry of Public Health, for example, was interpreted the mandate of the Women's Convention to introduce into national health policies a gender perspective that considers "the social discrimination of women as an element which contributes to the ill-health of women". To incorporate the Women's Convention into Colombian law, article 12 on delivery of health care was made part of the country's new 1991 Constitution.

In Brazil in 1992 the State of São Paulo and many of its municipalities developed their own Convention based on the principles of the Women's Convention. This Convention, named the Paulista Convention on the Elimination of All Forms of Discrimination against Women, requires implementation of the Programme for Comprehensive Care of Women's Health. The programme emphasizes the need for a range of women's health services, including services for reproductive health, cancer prevention, menopause and old age, victimization by violence and, for example, for groups of women among who conditions such as anaemia are of greater incidence. The programme also calls for measures to encourage normal birth and to fight the indiscriminate use of caesarean deliveries.

The removal of female stereotypes

Perhaps the greatest challenge faced in the improvement of women's health is the need to give effect of the Women's Convention, by which States Parties commit themselves to take all appropriate measures:

To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

Female genital mutilation, for instance, reflects a stereotypical perception that women may legitimately be exposed to non-therapeutic surgery in order to comply with the gender-specific norms of their community. While the sexes may rank equally as initiators of unchastely and adulterers may be equally condemned, loss of virginity is a greater stigma and barrier to marriage in women than in men, and men bear no health risks for premarital preservation of their virginity.

Where food is scarce - whether due to poor agriculture, poor climate or the family's poor socioeconomic circumstances - the sequence of feeding often gives priority to males over females so that food goes first to a husband, then to sons, then to the mother and any daughters of the family. This practice may be reinforced in certain cultures where women see the survival of their husbands and sons as being of paramount importance to their own survival. Similarly, in some cultures newborn daughters are breast-fed for fewer months than sons. The incidence of malnutrition and anaemia in girls is directly related to rates of sickness and mortality.

RIGHTS TO SURVIVAL, LIBERTY AND SECURITY

The right to survival

The most obvious human right violated by avoidable death - not simply in pregnancy or childbirth but also as a cumulative result of health disadvantages - is a woman's right to life, also described as the right to survival. This understanding of the right to life is essentially male-oriented since men assimilate the imagery of capital punishment as more immediate to them than death from pregnancy or labour. Feminist legal approaches suggest that this interpretation of the right to life ignores the historical reality of women, which persists in regions of the world from which come almost all of the 500 000 women estimated to die each year from pregnancy-related causes. The Human Rights Committee established under the Political Covenant has noted that: the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot he properly understood in a restrictive manner, and the protection of this right requires that states adopt positive measures.

Rights to liberty and free and informed consent

Major abuses of women's liberty and autonomy occur in the delivery of health services, in part because of lack of enforcement and misapplication of the legal concept of informed consent. The manner in which a health service is offered and rendered can in some cases be a significant element in the service's success or failure to promote health.

A great deal can be done to improve the application of the principle of consent in order to ensure that women are provided with adequate information to decide on a proposed course of medical or other health treatment.

The concept of informed consent to proposed treatment has two requirements, namely:

• That choice in health care be adequately informed;

• That consent to care be freely given or withheld.

The concept of "informed consent" is often used to cover both aspects of choice - informed consent or dissent and the right to unforced choice. The right to informed choice in health services, self-help and preventive health care is related to rights both to education and literacy and to rights to information and freedom of thought and association. The human rights of prospective recipients of health services have to be understood compatibly with the associated obligations of persons qualified to deliver health services.

Simple consent may consist only in agreement to comply with what is proposed. Such agreement is sometimes classified as "assent", as in the case of young persons who agree to be treated on the authorization of their parents. To exercise truly informed choice, a woman deciding whether to receive a health service must have sufficient understanding of:

• The proposed intervention;

• The implications of refusal of that treatment;

• Alternative forms of management of her circumstances.

The role of information is to contribute to the individual's liberty to choose whether or not to accept a proposed form of management: it is not to persuade or condition a person to decide in a particular way, even if that way may appear to the health professional who gives the information to serve the person's best interests. In other words, the right to informed choice includes the right to make choices that health professionals may consider to be poor choices. Paternalistic medicine has been prone to conclude that women's choices are incompetently made if they do not follow health professionals' recommendations and that therefore women can be displaced as decision-makers concerning their medical treatment.

A major failure of personal liberty and autonomy specific to women occurs when a patient has not been adequately informed of the failure rate of a method of family planning she is thinking of accepting and when use of the method results in an unintended pregnancy or unintended infertility. Health professionals have ethical and legal duties to individuals to provide accurate information on contraceptive failure rates so that clients may make truly informed health choices about contraceptive methods.

The decision whether or not to accept medical treatment is not itself a medical decision. It is a personal decision unique to each individual. The individual must make the decision in accordance with her personality, likes and dislikes, comforts and discomforts, and coals in life as influenced by personal, family, social, philosophical and related perceptions. The role of health professionals is to give the individual decision-maker medical and other health-related information that contributes to the individual's power of choice and does not distort or unbalance that power.

Further, a woman must be free from coercion and over-inducement in exercising choice. The health professional giving information must not add to the pressures and hopes that the woman will naturally experience. Women seeking health services often feel dependent on care-givers. Because they are reluctant to appear non-compliant or ungrateful, women frequently feel obliged to agree to whatever is proposed to them, particularly when those with the power of superior knowledge of medicine tell them that what is proposed is for their own good.

Where individual compensation is accessible, the disadvantaged position of women may be compounded and underscored. The basis of financial compensation is normally to put a patient in the position she would have been in had the wrong not occurred, in so far as the

difference can be calculated in monetary terms. This measure of compensation usually requires a complainant to show on a balance of probabilities that, had the health service been properly rendered, she would have enjoyed a health advantage.

The right to security of the person

In its widest sense, the right to security is equal to the right to well-being and coincides with the WHO understanding of health. Health contributes to security and security is a major component of health. Insecurity reflects not just a lack of health and resources but vulnerability to become disadvantaged.

Exposure to violence can begin in childhood, in sexual and non-- sexual ways. Girls are especially vulnerable since their principal values often appear, paradoxically, to be their sexual availability and their chastity. Preservation of virginity before marriage through circumcision denies girl children security against the known physical and mental consequences of female genital mutilation. Health dangers are also associated with obstacles to termination of pregnancies of young girls, whether inside or outside marriage.

WOMEN AND RIGHT TO HEALTH

General comment on women's right to health

The global indicators "Health for All" are relevant to the right to health care; they are intended for use in obtaining a global over-view and not in measuring State compliance with the right to health care as protected by human rights treaties. Moreover, WHO has indicated that the development of national strategies aimed at achieving greater social equity in health status would require the disaggregation of carefully selected indicators. Wider consultation between those involved in the fields of health and human rights will help to identify key measures for determining State compliance with treaty obligations relating to the promotion and protection of women's health.

Principles for the promotion and protection of women's health

The development of principles for the promotion and protection of women's health is another approach that might be considered. Such principles could draw on national women's health policies and experience in the development of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care which were prepared under the auspices of the Commission on Human Rights in close collaboration with WHO and adopted by the United Nations General Assembly, Principles on the promotion and protection of women's health could address, but not necessarily be limited to, the following issues:

Health status factors

• Health considerations important to women at different stages of their life cycle;

• The need to determine the special impact on women of routine health procedures and products;

• The importance of improving research on women's health requirements;

• The need to consider women's health requirements and circumstances in the development of research protocols;

• The importance of basing health policies on the most up-to-date scientific and technological knowledge;

Health service factors

• The importance of treating women with dignity and respect, including the provision of adequate information so that women can make informed decisions on particular courses of treatment;

• The rights of women as patients and the importance of confidentiality and privacy;

Conditions affecting the health and well-being of women

• The importance of ensuring a healthy and safe working environment;

• The importance of eliminating traditions and practices that have detrimental health consequences for women;

• The ability to identify and respond appropriately to women who live in abusive environments.

Differences between Women and Men's Health

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

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

Gender Inequalities in Access to Health Care

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

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

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

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

The Experience Health sector reforms have been criticized for failing to fully support women's reproductive health and rights. In practice, reproductive health in health services tend to focus on family planning, limited prenatal care and obstetric care and to cover interventions in women's child bearing activities. Some programs include a minimum of gender training. Adolescent girl's and especially older women's health tend to be marginalized. In practice, the relevance of men in reproduction is barely reflected in reproductive health priorities. Thus, women's right to health is limited to their reproductive health during their child bearing age and not at all stages of their lives. Violence against women, which affects women's and girls health at all ages, while recognized by the World Bank as a threat to their health, has received very little attention. Despite the focus on child bearing years, women's reproductive rights have been curtailed (Desai, 2004).

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

Critical to the cultural undervaluation of females are kinship structures typified by exogamous marriage rules, exclusion of females from the line of inheritance, and cooperation restricted to males related by blood (Dyson and Moore 1983). High fertility and low ages at first marriage are also typical of areas with gender-differentiated kinship practices (Dyson and Moore 1983). Although the child/woman ratio reflects mortality as well as fertility, in India the child/ woman ratio has the highest partial correlations with district-level Total Fertility Rates adjusted for undercounting (Vosti and Lipton 1991).

The excessive mortality of females that this reflects is commonly hypothesized to be due to discrimination against females, particularly female children, relative to males, in the allocation of food and health care within the household. Matlab Project area in Bangladesh, D'Souza and Chen (1980) found that female child mortality was higher than male after the neonatal period, and Chen et al. (1981) found pronounced sex differentials in the food and health care received by children. A study of two villages in West Bengal found that girls consistently had poorer nutritional status than boys among all socioeconomic strata, as defined by landholding and mother's education (Sen. and Sengupta 1983).

Women Empowerment

The ability of women to make decisions that affect the circumstances of their own lives is an essential aspect of empowerment. In order to assess women's decision-making autonomy, NFHS-3 collected information from currently married women on their participation in four

different types of decisions: their own health care, making large household purchases, making household purchases for daily household needs, and visiting their family or relatives. Of the four decisions asked about, currently married women, irrespective of urban or rural residence, are most likely to make the decision about purchases for daily household needs mainly by themselves: however, even this decision is made mainly alone by only one-third of all currently married women. Only 27 percent of currently married women make decisions about their own health care mainly by themselves and only 11 percent make decisions about visits to their own family or relatives by themselves. Women are least likely to make decisions mainly by themselves about major household purchases. For all decisions, the likelihood that a woman will take the decision mainly by herself, as well as the likelihood that she will do so jointly with her husband, are higher in urban areas than in rural areas. In contrast, the husband or someone other than the respondent or her husband is more likely to be the main decision maker in rural areas.

A woman's ability to control her fertility and the contraceptive method she chooses are likely to be affected by her status, self-image, and sense of empowerment. Women unable to control other aspects of their lives may be less likely to feel they can make and carry out decisions about their fertility. Women may also feel the need to choose methods that are less likely to be evident or which do not depend on their husband's cooperation. The number of decisions in which a woman has the final say is indicative of women's empowerment and reflects the degree of decision-making control women are able to exercise in areas that affect their lives. The indicator 'Number of reasons for which wife beating is justified' has an inverse association with a woman's greater sense of entitlement, self-esteem, and status and therefore her level of empowerment. The indicator 'Number of reasons a wife can refuse to have sex with her husband' reflects perceptions of sexual roles and of women's rights over their bodies and also indicates women's sense of self and empowerment.

Women's use of antenatal, delivery, and postnatal care services from health workers varies by level of women's empowerment as measured by the three indicators of empowerment. In societies where health care is widespread, women's empowerment may not affect their access to reproductive health services; in other societies, however, increased empowerment of women is likely to increase their ability to seek out and use health services to better meet their own reproductive health goals, including the goal of safe motherhood.

Women's empowerment in terms of decision making is not related to whether women received antenatal care, but access to appropriate delivery assistance and timely postnatal

care increases with the number of decisions that women participate in. For example, 52 percent of women who participate in most of the four decisions had a delivery assisted by health personnel and 37 percent received postnatal care from health personnel within the first two days after delivery, compared with 46 percent and 30 percent, respectively, of women who do not participate in any of the four decisions. The ability to access information, take decisions, and act effectively in their own interest or in the interests of those who depend on them are essential aspects of empowerment of women.

Nutrition and Health

In developing countries, children and adults are vulnerable to malnutrition because of low dietary intakes, infectious diseases, lack of appropriate care, and inequitable distribution of food within the household. Malnutrition in women and men can result in reduced productivity, slow recovery from illnesses, increased susceptibility to infections, and a heightened risk of adverse pregnancy outcomes. A woman's nutritional status has important implications for her health as well as the health of her children. A woman with poor nutritional status, as indicated by a low body mass index (BMI), short stature, anaemia, or other micronutrient deficiencies, has a greater risk of obstructed labour, having a baby with a low birth weight, having adverse pregnancy outcomes, producing lower quality breast milk, death due to postpartum haemorrhage, and illness for herself and her baby.

Under nutrition is substantially higher in rural areas than in urban areas. Even in urban areas, however, 40 percent of children are stunted and 33 percent are underweight. Children who are judged by their mother to have been small or very small at the time of birth are more likely to be undernourished than those who were average size or larger. Under nutrition has a strong negative relationship with the mother's education. The percentage of children who are severely underweight is almost five times as high for children whose mothers have no education as for children whose mothers have 12 or more years of education. Hindu and Muslim children are about equally likely to be undernourished, but Christian, Sikh, and Jain children are considerably better nourished. Children belonging to scheduled castes, scheduled tribes, or other backward classes have relatively high levels of under nutrition according to all three measures. Children from scheduled tribes have the poorest nutritional status on almost every measure, and the high prevalence of wasting in this group (28 percent) is of particular concern. There is not much difference in nutritional status for children by whether or not the mother was interviewed, but it is interesting to note that children who do not live with either

parent have slightly better nutritional status than those who live with both parents or with only one parent (NFHS-3).

Breastfeeding improves the nutritional status of young children and reduces morbidity and mortality. Breast milk not only provides important nutrients but also protects the child against infection. The timing and type of supplementary foods introduced in an infant's diet also have significant effects on the child's nutritional status. Most mothers (57 percent) gave their last-born child something to drink other than breast milk in the three days after delivery.

All the above points are interlinking with each other by accessing health care system for women and nutritional status of their children.

CONCLUSION

The impact of globalization on health is very complex. Changes take different forms in different places and culture. Impact on individuals varies with age, ethnicity, socio- economic status and both sex and gender important aspects of this diversity. Low economic and cultural worth reinforce each other to produce especially high gender inequality in mortality. This result suggests that raising the economic worth of females in countries where their cultural worth is low or raising their cultural worth in countries where their economic worth is low would be effective in reducing gender inequality in mortality. Access to women health care is only possible through liberty. When a woman has better decision making power regarding health, she must be more careful in favour of her children health and nutritional status. Mother education and nutritional status of the child are interrelated. Under nutrition is much more common for children of mothers whose body mass index is below 18.5 than for children whose mothers are not underweight. Inadequate nutrition is a problem throughout India. This ratio is more particularly in Tribal belt society. This may be for their socio-cultural perception or may be lack of awareness. So either directly or indirectly human right or liberty plays an important role for both women and child health care. India is a developing country where gender discrimination in health care sector is more. Now there is need for more research on differential impact of global restructuring on health of women and men. More detailed studies needed of complex and contradictory effects of change on well-being of women and men in different settings in accordance to accessibility, affordability and equity in health care sector. These will provide basis for improved policy making in the health sector and other social advancements.

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