Impact of Globalization & Liberalization on Women’s Health in India- Future Strategies

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Abstract

The liberalization and globalization has impacted all areas of living setting in a chain of pervasive changes. The era of economic reforms in India since 1990 has had far reaching effects on issues of gender & society. Globalization is associated with free trade, free mobility of both financial and real capital, and rapid diffusion of products, technologies, and information and consumption patterns.

In a democracy, the greatest good of the greatest number is the accepted guiding principle. Social and economic inequality is detrimental to the health of any society. Especially when the society is diverse, multicultural, overpopulated and undergoing rapid but unequal economic growth. There are obviously tensions within classes and communities, and therefore what ensures good quality for one group may not do the same for others. Gender inequalities pervade through the entire spectrum of society. The socio-cultural determinants of women’s health have played a lead role in the persistence and strengthening of health inequalities. This paper attempts to review the effects of growing socio-economic inequality in Indian population and its effect on the healthcare system. It tries to identify the factors responsible for the difficulties in healthcare delivery in an unequal society and its effect on the health of a society. The primary challenge to health empowerment and socio-economic rights stems from poverty & underdevelopment.

The paper analyses the impact of globalization & liberalization on women’s health in the patriarchal Indian culture. It compares & contrasts both the positive and negative outcomes. It is written in Indian context from the women's standpoint. The paper defines the concepts of globalization, the various structural adjustments & trends in the economic world & its interrelationship with the implications for women's health in India. It then examines the processes whereby globalization impacts upon the health of women & summarizes the overall impact presenting strategies for future.

The women’s empowerment in the health sector needs to be redefined. The empowerment approach in health has to move beyond describing men and women's health in isolation and brings into the analysis of how gender differences, exposure to risk, access to benefits of technology and health care, rights & responsibilities and the control exercised by people over their lives have been altered by globalization. The issue of sex ratio, son preferences, early marriage, poor health and nutrition, maternal mortality etc has been reviewed in the transitional Indian society.

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It is only now, a decade & a half after the acceptance by India of economic liberalization and market oriented growth as strategy for development that reports of their impact is being recognized. The Indian Governments has adopted an increasingly open stance towards the world economy & in greater numbers have sought to reduce barriers & divisions between economic activity within their national boundaries and beyond. They lowered tariffs & other barriers to international trade & removed controls on foreign exchange transactions to promote the free flow of goods & capital. The shift towards greater openness in relation to all forms of capital flows seems to have gained much greater momentum within the past decade. It was originally contended that with increasing trade & foreign direct investment (FDI), the overall status of women in the developing world would improve. Globalization would be a tool to better women’s conditions by providing them with increased economic freedoms and an enhanced status in society. So much so that different sectors of economy have different experiences about the impact of those reforms. The policies for globalization adopted in India definitely have
significant implications for women’s health in addition to their impact on overall economic growth of the country. But the results of unfettered operation of market forces has not been equitable, especially in India, where some groups are likely to be subjected to disadvantage as a result of globalization. Women constitute one such vulnerable group and globalization has both positive and negative effects on their status.

India, with a population of 1,049,700,118 (2003) is the world’s second most populous country. Of this, 120 million are women who live in poverty. India has 16 percent of the world’s population, but only 2.4 percent of its land, resulting in great pressures on its natural resources. The major development challenges in health care are adverse sex ratio, high fertility and mortality rate, high maternal mortality rate along with 54 per cent of India’s women being literate. Health expenditure per capita is $71 (2000). India is fast becoming the 2nd major country to be infected with HIV/AIDS.

Globalization processes have shaped the lives of women & men in very different ways. Women do not respond to problems in the same manner as men. New market forces have redefined women’s health accessibility which in turn has also reconfigured their status. Globalization is integration of the world market into seamless society without artificial barriers created by nations, physical restriction on labor and services and restrictions on investments. Liberalization is the domestic response to the globalization process and pressure of global forces i.e. opening up of the economy. It is vital to understand the culture to see the health links of women’s health with globalization. Culture is defined as all of the beliefs, behaviors and products common to members of a particular group. These include the values and customs that we hold in common to others, the language that we speak, the rules we follow, the tools and technologies we use to make things. Health is defined as a state of mental, physical and social well being. There should be interplay of psychological, physiological and sociological factors in a person’s sense of well-being.

**Changing Development Approaches to Women:**

The development of women has always been the central focus of the developmental planning since independence. The shifts in policy approaches in the last 50 years from the concept of welfare in the 70's to development in the 80's and now to empowerment in the 90's are fully reckoned with. The most significant turn around strategy was in mid 80's with the Seventh Plan, which started and move towards the equality and empowerment. The Eighth Plan marked a further shift towards the empowerment of women emphasizing women as equal partners in the development process. The Govt. of India has ushered in the new millennium by declaring the year 2001 as 'Women's Empowerment Year' to focus our vision in the new century of a nation where women are equal partners. However, health empowerment still remains a distinctive problem for Indian women as exemplified by the health statistics. The employment of women is one of the main objective of India's ninth & tenth Five Year Plan and enhancing women's capacity, correcting gender imbalances, especially in health, nutrition and education and promoting greater participation in economical and political decision making processes. The National Health Policy 2002 has also emphasized the need to take care of women’s health in special ways. At present, the National Policy for Empowerment of Women is being finalized by the Department of Women & Child, which describes strategies and action points to bridge the gap between equal de-jure status and unequal de-facto position of women in the country. There also has been a significant conceptual shift in recent years from a target oriented approach to population and health issues towards a more need based comprehensive approach to women's health. The health concerns of girl’s originate much before her birth and the life-cycle approach is now thought of as the coping strategy. The challenge is to ensure that women's health is a public health priority throughout her life from birth till old age.

The persistence of sharp gender inequalities in many different forms is one of the most striking aspects of Indian economy and it yields disparities in well-being as well as differences in power and decision-
making authority. The most explicit case of gender inequality is to be found in the low female-male ratio in India and the high proportion of 'missing women' whose absence can be attributed to differential care including medical attention. Gender inequality does not decline automatically with the process of economic growth. The cultural and socio economic environment affects women's exposure to disease and injury, their diet, their access to and use of health services.

In this paper effort has been made to highlight the cultural issues prevalent in Indian society that have influence women's health in India along with a series of changes led by the processes of globalization. The current perspective of health is much more than a mere medical issue and not just confined to biological factors and medical intervention.

**Historical Moorings & Socio- Cultural Beliefs:**

Women's health and nutritional status is inextricably linked with social, cultural, and economic factors that influence all aspects of their lives, and it has consequences not only for the women themselves but also for the well-being of their children the functioning of households, and the distribution of resources.

The status of Hindu woman during the Vedic period was high holding women in high esteem. They enjoyed equal social and religious status & had equal opportunity for education. However, it was during the post-Vedic period, women started losing the status in society. Women were debarred from the study of Vedas & were treated more on emotional and less rational plane. The Institution of caste becomes very rigid with strict hierarchical *Brahmanical* order. Inter-caste & widow marriages were not allowed. Further after the foreign invasions the socio-economic status of Hindu women deteriorated. The social practices like *purdah* system, sati & child marriage came into force. During the British rule in India, legislation brought about significant modifications in the structure of society. Various reforms were initiated to improve the status of women. After attaining freedom, the constitution guarantees equal opportunity & status to men & women.

Even today in a large number of Hindu households, the birth of son is celebrated while the birth of a daughter is a cause for anxiety. The assumption of superiority of males has built up the ideas of male dominance and female dependence. Most of the major decision – making roles is thus the domain of man. In India girls are considered an economic liability because of the tradition of dowry. Indian society has had a culture of *Kanyadan and Vara-dakshina* (Dowry) where the parents offer their daughter to the bridegroom and give affectionate gifts in kind or cash with the intention of setting up the household of the new couple at the start of their life together. Over a period of time these cultural attributes became a social compulsions and the whole process has been commercialized. For many families, the dowry represents an enormous financial burden. Because of the perception that girls are a drain on family resources, in some cases families are unwilling to invest in daughters.

Female literacy stands at 54% compared to men. The gender gap in education is far greater in the northern states. Even in states where enrollment rates for girls are higher, many girls drop out of school after only a few years of education. Cultural factors such as inhibition on education being imparted by male teachers to girls once they reach puberty, is responsible for dropouts.

Women derive their status primarily from their childbearing role and their value is often measured by the number of sons they have. They depend on male children for social status and economic security and are often reluctant to use contraception prior to having a son. Family planning practice rises significantly among women who have two or more sons. The cultural practice of women eating last in the family takes a toll on her health.

The status of women's health is largely reflected by the indicators like female mortality and morbidity, disease burden, reproductive health and encompassing reproductive behavior, contraception, abortion, maternal mortality and morbidity, gynecological morbidity and infertility; nutrition; work environment
and health covering aspects like poor sanitation, air pollution, poor quality of housing, degradation of natural resources, sexual harassment and health problems related to nature of women's productive work; and violence against women and its consequences for the health care system of women. Malnutrition is often caused by the gender discrimination in food distribution, presents a serious threat to health of girls and women. Women's risk of premature death and disability is higher during their reproductive years. MMR (447) and IMR (70) coupled with educational backwardness of women's, result in low social and economic status limiting the women access to education, good nutrition, family planning services and health care. The main factors determining women's health are:

Poverty & Economic Inequalities: It is estimated that out of 1.3 billion people living below the poverty line, more than 70% are females and the major brunt is borne by women of rural areas. Unequal opportunities in education and employment, inheritance and restrictions on the physical mobility of women, deny them the autonomy and the right to make decisions concerning their lives, which all result in deprivation of both the capabilities and entitlements to women. Gender inequality further worsens the situation.

Women's Position in Family & Society is based on considerations like the birth of son, Restrictions on Physical Mobility, dowry, marriage, divorce, inheritance, literacy & education, work participation rates, dual burden.

Access to Health Services: Women's health needs differ from men because of biological differences and also as a result of gender differentials in exposure to risk factors. Therefore they are more vulnerable due to the impacts of globalization. The four factors, which determine women's access to health care are:

Extent of ill health amongst women;

Promotion - crucial factors influencing whether women can seek health care;

Ability - economic factors enabling women to meet the cost of health services; and

Availability - the network of health services and access to it.

IMPACTS OF GLOBALIZATION: Entry into the labor market

The economic impact of globalization has changed the labor market dynamics and is believed to have played an important role in the upward trend in female employment in waged work. The labor force participation rate of women is 22.7%, less than half of the men's rate of 51.6%. FEAR (Female Employment Activity Rates) for India is 42 per cent (Human Development Report 2001). The female to male ratio of participation in economic activity (F/M) is less than 100 in all countries except China while for India the F/M ratio is 50. Much of the increase in employment arising from globalization has resulted in the movement of female labor from the household and subsistence (agriculture) sector, to paid employment. The feminization of the manufacturing sector is main feature in India while it is the services sector in all the South Asian countries. Positive effects include increased employment opportunities for women in non-traditional sectors, thus enabling them to earn and control income. This is potentially empowering & contributes to enhancing women's capacity to negotiate their role & status within the household & society. Increase in women's employment is thought to modify the balance of power within the household. By bringing home wage income, women attain a greater say in household expenditure decisions with respect to both consumption & human capital investment.

The effects of globalization have been increased labour market flexibility, casualization and informalization of employment & the proliferation of "contingent" jobs which are typically short-hired
The feminization of labor occurring as a part of the process of flexiblization of labor has increasingly pushed women out of the core workforce and into marginalized group of workers, consisting of part-time, temporary, casual, and sub-contracted labor. In India the process of informalization of the labor force has taken place broadly in two ways. Work is pushed out of the factories and formal work situations into small workshops (sweatshops), the homes and informal situations. Secondly, the workers who remain in the factories or in formal work situations are governed by looser contracts and obtain fewer social security benefits. New working conditions which include sub contraction, piece-rating, flexible work scheduling and part timing has marginalized them. As a result, they are not recognized as regular workers & their basic rights not guaranteed.

According to Vandana Shiva, and Indian ecofeminist & scholar, “Globalization along with the support of organizations such as the WB & IMF has created slave wages. These wages are not necessarily the result of “unjust” societies, but of the fact that global trade devalues the worth of people’s lives and work”. While globalization has brought jobs to rural areas where there was previously no employment, these jobs seem to be wolves in sheep’s clothing. The work available to women is almost always poorly paid, mentally and physically unhealthy, demeaning, or insecure”.

Trade liberalization has also led to loss of employment in the formal sector in India, often with gender-differentiated results. The increased competition from low-cost Asian producers has had the effect of displacing workers in labor intensive industries. If export expansion has a positive effect on women’s employment in the informal sector the opposite may also be true for import expansion. The direct effects from import expansion tend to be negative. Cheaper imports displace women's employment disproportionately in the informal sector. The poverty & destitution of many families has increased especially among women & children. The declining income and inflation have combined to make it difficult for many households to maintain adequate nutritional levels.

**Poor Working Conditions:**

The extent to which women in terms of their health welfare are generally helped or harmed by such a switch in strategy depends on both the nature of employment created and peoples’ preferences e.g factory work may pay better than alternative forms of employment, but the work may be seen as less pleasant and working conditions less flexible. Poor working conditions have serious health implications. Long hours, congested working conditions, strict supervision of work & long hours of travel times to work are considered the norm. However, conditions are worst in the smaller local firms. Women employed with little or no training on the job, are quickly dispensed with when they become pregnant or marry. Home-based work generally involves low pay, socio-economic invisibility, and long hours of labor. Additionally, compared with in factory workers, who produce goods of the same quality and quantity, they are paid considerably less. They are often semi-skilled workers and poorly educated & subject to insecurity of work availability. Income is only earned when work is available, and because workers are paid at low rates, home-workers tend to labor long hours in order to earn as much as possible.

**Migration:**

The current trends are towards new and complex forms of labor movements, both legal and clandestine, which have emerged: in addition to the traditional "brain drain". There is temporary migration of contract labor, trafficking, the flow of personnel, crisis-prompted population displacements with economic consequences affecting women the most. In the international migration it has made women more vulnerable in terms of their employment as entertainers, trafficking, rising incidence of AIDS & HIV infections. According to National AIDS Control Organization (NACO) estimates, there are nearly 5 million people living with HIV/AIDS. Most HIV/AIDS initiatives are funded by international agencies which have the resources but in return exercise control over the HIV/AIDS discourse in the
country. Till recently, the Indian government did not support ARV (anti-retroviral) treatment because of its prohibitive cost.

**Mechanization & Technological Changes:**

The technological revolution which has accompanied the process of globalization & the free flow of information has had the adverse effect of facilitating the gender preferences through the sex selective abortions. The sex ratio is 933 but in certain regions particularly Punjab, Haryana & parts of Rajasthan too it touches 850.

**Structural Adjustments & Major trends:**

- PRIVATIZATION of Health Services – affordability, accessibility, quality
- DECLINE IN EXPENDITURES ON HEALTH -Much of the reproductive health budget is allocated to family planning services.
- DECREASED SOCIAL PROVISIONING by the State-” hollowing out” of nation states
- HIGH COSTS of health services including prescriptive drugs, user charges
- POORER NUTRITION: World Bank recognized that 44 low income countries do not have the money to pay for basic minimum health services. These cuts have affected women’s reproductive health needs.

**Privatization of Health Care**

The privatization of health care has accelerated since 1991 with the unprecedented expansion of the private medical sector, the entry of private insurance in health care and the introduction of payment for medical services or “user fees” in the government sector. Level of public expenditure in the health sector is the lowest in the world. Of the aggregate expenditure on health 83% is allocated to private spending, while 43% of the poor depend on public sector hospitals for care. Privatization & deregulation have resulted in rising drug prices. New National Health Policy 2002 legitimizes the ongoing privatization of health. The Indian health system is the most privatized health system in the world as per the reports of Citizens Report on Governance and Development 2003, Social Watch India. While the proclaimed objective of user fees is to generate resources for the public sector, it has resulted in people being weaned away from public to private hospitals as people do not want to settle for what appears to be `second best' if money has to be paid in both cases. It has also meant that a large number of people are not seeking help from anyone. This has led to a paradoxical situation where the standard of medical care in public hospitals is degenerating even as user fees are introduced as a source of income.

**Accessibility & Affordability:**

The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban-biased, tertiary level health services with profitability overriding equality, and rationality of care often taking a back seat. The increasing cost of healthcare that is paid by ‘out of pocket’ payments is making healthcare unaffordable for a growing number of people. Trade liberalization allows the entry of cheap products including cheap health products. Health care is now profit-driven. When there is a drive to derive a profit from health care, it ceases being a basic right and a basic social service. It becomes a privilege unreachable to the poorer segments of the population, enjoyed only by those who have resources. If the country's economy has to fight an unequal battle with the developed countries in the international market, its society is doubly burdened by the inequities suffered by women, enhanced by the effects of this unfavorable competition.

The availability of services for women suffering from gender-based violence is either inadequate or non-existent. Most of the other countries have reported extensive gender-violence problems. However,
barriers such as socio-cultural stigmatization, under-reporting of cases and lack of national prevalence data have undermined the seriousness of the problem. Malaysia and Philippines were the only two countries, which have set up multi-disciplinary integrated public health services for women.

Privatization has led to the sale of government land and closure or scaling down of vital public hospital services in mental health, leprosy and TB. NGOs in India have been raising the issue that spiraling costs of medicines are a growing barrier to healthcare. In India, the increased cost of medical care is the second most common cause of rural indebtedness. Women place their health needs last when cost is an issue, seeking medical care too late or not at all.

High Costs & Drug Policy:

In India, price controls to make sure that essential drugs are available to the public at an affordable rate is done through the Drug Price Control Order (DPCO). The numbers of drugs that are under price control have come down from 347 in the 1979 DPCO to the current 35 which is about 22% of the total market. The consequence is decreased access to drugs and health care systems, especially the marginalized sections. Bulk drug manufacturing units have closed down due to liberalized import & dumping -implementation of the WTO agreement. Due to reduction of customs duty & increase of excise duty, imported drugs are cheaper while local drugs will become more expensive.

The Pharmaceutical Policy 2003 is another issue at stake which has contributed to the process of making the Drug Price Control Order mechanism ineffective. This mechanism was instituted in 1978 to keep the prices of all drugs under control. However, the number of drugs under this scheme has now decreased to 35, which is about 22% of the total market. Spurious drugs are a major concern that the government has to tackle. The government needs to re-examine the current drug pricing policy. Mechanisms are not in place to ensure that poorer countries do not get dumped with poorly tested medical drugs and supplies, that adequate medicinal supplies is attainable at reasonable costs, that labor is allowed to move freely without fear of discrimination. Liberalization has only widened the gap. Drug prices in this country have been soaring steadily since India passed legislation to comply with Trade Related Intellectual Property Rights (TRIPS) rules last year. Given that almost 40 percent of the Indian population live in poverty, people’s health are certainly threatened, especially the health and well-being of women. The economy, strained to the utmost under the challenges of globalization, is unable to bear the burden of necessary health-care expenses. The weaker sections, especially the women, are denied the physical care they deserve. The imposition of user charges & high costs of prescriptive drugs has denied access to many. Although contraceptive services and supplies have been affected in India, this remains the most affordable and accessible reproductive health service for women due to the priority of the population problem. Much of the reproductive health budget is allocated to family planning services.

Decline in Health Expenditures:

The level of public expenditure in the health sector is the lowest in the world. The Indian health system is the most privatized health system in the world. Public health expenditure, which is currently below 1% of GDP, is far below the 5% of GDP recommended by WHO. Of the aggregate expenditure on health 83% is allocated to private spending, while 43% of the poor depend on public sector hospitals for care. The already meager health expenditure decreased drastically in the 2004 budget. As stated in the Citizens Report on Governance and Development 2003, Social Watch India, “the level of public expenditure in the health sector is the lowest in the world. The Indian health system is the most privatized health system in the world. Of the aggregate expenditure on health 83% is allocated to private spending, while 43% of the poor depend on public sector hospitals for care. Privatization and deregulation of the health system have resulted in rising drug prices. Riddled with contradictions as it is, new National Health Policy 2002 legitimizes the ongoing privatization of health with an impossible
wish to uplift a quarter of the population living below the poverty line.

**Decreased Social Provisioning:**

These reforms led to a decrease in government spending on health programs which have had far reaching consequences for the health and well-being of women. Poor women, it has been argued are especially disadvantaged and have been most affected by structural adjustment programs (Isla, 1993b).

Government expenditure on public health care has declined sharply since the beginning of reforms and structural adjustment in 1991. The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 17% of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. With this health care in India is one of the most privatized health care systems in the world. Since health is a State subject under the Constitutional framework, States are expected to contribute to a major part of the finances allocated to the health sector. But the budgetary allocation of States for health has declined form 7 per cent to 5.5% in the period between 1990 and 1999. The National Health Policy, 2002, aims to increase it to 25 per cent by 2010. There has been an overall decrease in spending on the social sector especially vis-à-vis the marginalized sections like the Dalits, Adivasis & women. Public health expenditure, which is currently below 1% of GDP, is far below the 5% of GDP recommended by the World Health Organization. Privatization and deregulation of the health system have resulted in rising drug prices. New National Health Policy 2002 legitimizes the ongoing privatization of health.

**Globalized Agriculture & Reduced Food Security:**

The effect of agricultural diversification and decline in subsistence crops into cash crops has impacted on domestic food production. Income from employment though has enhanced a women’s autonomy, more say in how the household is run and improvements in the nutritional status and well being of all members of the household, especially the infants yet it has led to dual burden which has deleterious effects on the woman’s nutritional status, if she works long hours and still has all the domestic responsibilities. In most cases, the reduction of household resources devoted to subsistence production has had the effect of diminishing food security even when total household income increased because of cash crop production (Lado, 1992). This is because the income from crops, which men customarily control, is not generally pooled in the household, while women’s income is mainly used for food and other necessities. That explains why increase in cash income controlled by men does not necessarily translate into improved household nutritional intake and food security. Skyrocketing food prices and export-oriented cropping pattern in agriculture contributes to women's declining access to food and nutrition. The less than satisfactory public distribution system deteriorates under the SAP, and brings extra sufferings to women, especially to women heading households. As globalization has led to reduced food security & therefore the most direct effects of poor health and nutrition among females in Indian society are high mortality rates among young children and women of child bearing age and morbidity rates throughout the life cycle. A woman’s health and nutritional status influence her newborn’s birth weight and chances of survival, her capacity to nurse and nurture her child and her ability to provide food and care for the family members. Infectious diseases generally cause post neonatal deaths. The incidence and severity of most of these diseases are affected by controllable factors such as immunization, health care and nutrition. Where gender bias exists, these factors are not controlled equally for male and female children. The long- term benefits of such policies on the promotion of economic growth and reduction of poverty have failed to materialize. This is attributed largely to the failure of the WTO to achieve a fair balance between the liberalization of trade in manufactured products and the protection which developed countries give to their agricultural producers.
Male migration to cities in search of employment has left women farmers to take on traditional male tasks in agriculture. The general trends have been:

- Women have been incorporated into paid employment in large numbers in the past two decades, but usually under conditions inferior to those for men.
- The cost of economic adjustment has been borne disproportionately by women, especially poor women.
- The welfare demands placed on the as a whole family and women have increased, because of a reduction in state social sector expenditures.
- Women are found in agricultural sectors but mostly with no rights to lands.

Maternal mortality in India estimated at 447 maternal deaths per 100,000 live births, result primarily from infection hemorrhage, obstructed labor, abortion and anemia (The World Bank, 2003). Malnourished women are more likely to give birth to low birth-weight babies, and if the underweight baby is a female who survives, she in turn is likely to continue to be undernourished throughout her childhood, adolescence and adult life. This lack of nourishment has detrimental effects on her reproductive and lactating capacities and overall development.

Social Costs:
Social development indicators include improved health & education such as declining infant mortality, rising literacy rates, reduced fertility. One major question is whether economic development leads to social development, particularly in ways that allow women to close the gap with men in measures such as health & education. It is generally agreed that higher overall education levels improve infant mortality & fertility indicators, but in India with large gender gaps in the education enrolment rates perform less well, indicating that cultural fact an important role besides just economic development. These correlations may also indicate complicated interactions between the indicators, as well as underlying forces driving the indicators. The mixture of corporate capitalism and Western culture models is dissolving family and community social controls as witnessed by higher rates of family violence, rape, divorce, and family breakdown. Family is a strong social security net in Indian society. It has been a cultural norm to take care of the elderly. However, breaking up of the traditional joint family system and erosion of social values has made women more vulnerable with respect health status. They suffer from neglect, loneliness, alienation, and poor nutrition status apart from physical ailments. Since globalization is introducing technological inputs, marginalization of women in economic activities & since SAP has led to the unemployment of a large number of men, and has increased frustration, tension and a fear of job insecurity. Women are being made to pay the social cost. Family violence has increased, rape has become an everyday event, and dowry deaths are escalating. These are threats to women’s health. At times of economic crisis the psychological stress on women becomes even more heighten as they are called upon to offer emotional comfort to family members in difficult times.

Empowerment of women:
Increase in women’s employment is thought to modify the balance of power within the household. By bringing home wage income, women attain a greater say in household expenditure decisions with respect to both consumption and human capital investment. As a result, a proportion of household budget can now go to support women’s (and girls’) well being, health needs and income-earning capacity. In practice, however, paid employment does not always mean empowerment for women in health sector. Rising female wages do not always result in positive benefits for women. Women are barred through traditional custom from deciding upon the use of their monetary contributions to the
family budget, then a view of family bargaining that states that equal contributions to the household leads to equal power within the household do not hold. Women may increase their share of market work but not necessarily with a corresponding reduction in their non market responsibilities and with no additional control over family resources that could be used to ease their burden of domestic responsibilities.

**Commodification of Women’s health Needs:**

With the growing pressures of globalization, supported by some international organizations (e.g. World Bank, IMF) as the better way of ensuring cost effectiveness and efficiency of economies, we find that governments' responsibility for social welfare is in danger of dying, and with it, progressive ideas and models of national health services. By allowing globalization through deregulation, privatization and free trade under the guise of increasing cost effectiveness, governments are practicing a more insidious form of colonization which commodifies women and the poor into dispensable and cheap factors of production. Privatization of health care commodifies and targets women's reproductive health needs, providing TNCs and MNCs a large opportunity for profit-making at the expense of burdening women with increased health costs.

**NGO’s & Civil Society Movements:**

Many of the domestic & international NGO’s have raised common issues of women’s health. Governments need to recognize that NGOs can only point to weaknesses and gaps of a public healthcare system, and even show on a micro-level how a gender-sensitive and women-centered healthcare model could be implemented well. Dismissing NGOs' findings as too small-scale and irrelevant cannot be seen as constructive actions. What governments could do is closely examine such good practices and models and provide support for up scaling or to pilot-test such models in other parts of the country concerned. Women's access to affordable, quality reproductive health services needs to be evaluated more fully, as their access is limited according to their income.

The SAP has not provided any physical or psychological base Globalization/ SAP has not ensured a good quality of life for the majority of Indian women but has reinforced the existing gender inequalities. The Beijing platform while recognizing the gender disparities in access to health care had noted “women have different and unequal access to and use of basic health resources, including primary health services for prevention and treatment of childhood diseases, malnutrition, anemia, etc. Women’s health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate health services to women”. This access is further complicated due to gender differences at all levels. What is required is a through filtering of cultural norms and biases, tackling poverty, improving literacy, increasing awareness for the importance of girl child to be same as that of a male, provision of adequate family welfare services – which to a large extent is being done as a part of the government’s policy for enlistment of women.

The Empowerment Approach in health has to move beyond describing men and women’s health in isolation and brings into the analysis of how differences between women and men determine differentials, exposure to risk, access to benefits of technology and health care, rights and responsibilities and the control exercised by people over their lives. The gender empowerment approach while not excluding the biological factor, have to account for critical roles with social, cultural factors and power relations between men and women play in promoting and protecting health. Women’s empowerment has to seen in a “relational context” e.g. obstacles to women’s empowerment cannot be understood without a clear vision of the relationships, roles, responsibilities and inequalities between men and women. Others can help to create conditions favorable and support processes that work in this direction. There are many dimensions to women’s empowerment including personal, collective, national and global as well as economic, social and political. It is also important to ground
specific understandings of empowerment in day-to-day contexts realizing that concrete reality of 
women’s lives differs from place to place.

Amartya Sen rightly remarked that ‘freedom to make decisions about fertility is the cornerstone for 
women's empowerment’. He observed in 1994 "central to reducing birth rates .......... is a close 
connection between women's well being and their power to make their own decisions and bring about 
changes in the fertility pattern................ Reduction in birth rates are typically associated with the 
 improvement in women's status and their ability to make their voices heard - often the result of 
expanded opportunities for schooling and political activity". The capability approach to a person's 
well-being would, therefore, entail assessing that person's ability to achieve various valuable 
functioning’s and the ability to choose from a combination of alternatives in leading a life. The right to 
regulate one's fertility is often restricted. In reality, the freedom of reproductive choice is an illusion in 
many societies where women are subordinated and their possibility of challenging authority of husband 
is extremely limited. The laws and regulations on contraception and abortion, insufficient reproductive 
health services and lack of decision-making powers, are the obstacles for exercising a free choice.

It is time leaders, policy makers and administrators to stand up against the dehumanization of half of 
the population.

A concerted effect to change societal attitudes, elimination of all forms of biases, prejudices and 
discrimination, active participation of women in all spheres of life, incorporations of gender 
perspective in policies and plans, gender auditing and finally, making them 'visible' and being 'heard' at 
family, regional, national and international platform. There is a need for regulatory frameworks 
designed to protect women from the negative effects of globalization with regards to health and safety, 
occupational standards etc. Governments should place limits to some forms of privatization of public 
healthcare services and further ensure that adequate infrastructure is in place for women to reach these 
services. Additionally, women should be empowered in the decision-making process to gain access to, 
and control over resources. More emphasis should be placed on gender sensitive policies to address 
some of the gender inequalities associated with the new economic integration and expansion of markets 
resulting from globalization.

The greatest challenge is to minimize or offset the damage resulting from impacts & consolidate the 
benefits. This could be achieved by enabling women to take power & control over their life situation & 
redefining ways of giving women the power to utilize the globalization process to their advantage, 
economically, socially & politically & also implementing information culture to enhance learning 
potential & skill & to increase access at all levels. It is essential to maintain cultural & creative 
diversity in a globalized world promoting a culture of peace in all fields & all walks of life. There is a 
need to develop comprehensive international & national strategies & policies & devise & implement 
preventive programs, develop & implement social welfare & health insurance system to ensure 
sufficient funding for women’s health care service. We also need to improve access & to evolve 
specialist women-friendly medical treatment & improve quality of life & health of menopausal & older 
women. Strengthening of the social protection mechanism, transforming structures of subordination, 
compliance of labor laws & agreements, maximizing the potential of Self help groups, NGO’s & 
interweaving health into their agenda are the call of the day.