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HEALTH AND GIRLS' EDUCATION IN SOUTH ASIA: AN ESSENTIAL SYNERGY

Vimala Ramachandran

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HEALTH AND GIRLS' EDUCATION IN SOUTH ASIA: AN ESSENTIAL SYNERGY

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SERIES FOREWORD

There is a growing sense of momentum around education in South Asia. Governments are engaged and a lot has been done. The Millennium Development Goals have added an additional spur to action as indeed have greater awareness on gender disparity and the need for educated workers. There is though a long way to go if the rights of all children are to be realized.

Providing access to education is only part of the story. Once children are enrolled and attending, the quality of their education must make it a worthwhile experience. The special needs of girls in the social and cultural context of South Asia call for special measures, as do the needs of all children in situations of conflict and emergency. South Asia has many rich, positive examples of success in advancing basic education. It is important that these are shared and built on if there is to be an overall improvement throughout the region.

This series of papers aimed at promoting better education in South Asia grew out of collaboration between the UNICEF Regional Office for South Asia and the newly formed UN Girls' Education Initiative, and had its genesis at a Regional Meeting on Accelerating Girls' Education in South Asia in February 2005.

Essentially the series is intended to be a forum that allows debate, exchange of ideas and to break new ground. It will aim to capture the momentum and extol good practice to all engaged in educational policy and implementation.

The series does not seek to represent a specific viewpoint, but rather is intended to enable specialist contributors to present issues in greater depth and breadth than is often the case in official documents.

Initially the series will focus on girls' education but it is hoped that eventually it will broaden into a platform for more general education issues related to South Asia, with a particular emphasis on social inclusion. Contributions and feedback are invited from academics and practitioners from throughout the South Asia region and beyond. The series editors are particularly interested in submissions which offer new ideas and strategies that can assist those needing answers, and which can add impetus to the ongoing efforts in the region to provide quality education for all.

Come, join the debate!

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Vimala Ramachandran

ACRONYMS

ART	Antiretroviral Therapy
ASER	Annual Status of Education Report – brought out by Pratham in India
B-HDR	Bangladesh – Human Development Report
BPL	Below Poverty Line
BRAC	Bangladesh Rural Advancement Council (a prominent NGO)
CMR	Child Mortality Ratio – death occurring in the first five years after birth
EFA	Education for All
GDI	Gender Related Development Index
GEM	Gender Empowerment Measure
GER	Gross Enrolment Ratio
GMR	Global Monitoring Report (for Education for All)
GoB	Government of Bangladesh
GoI	Government of India
GPI	Gender Parity Index
HDI	Human Development Indicators
HDR	Human Development Report (UNDP)
ICPD	International Conference on Population and Education
IDU	Injecting Drug Users
IMR	Infant Mortality Rate – the number of newborns dying under a year of age divided by the number of live births during the year
KGBV	Kasturba Gandhi Balika Vidhyalaya – a residential upper primary school for girls in educationally backward blocks of India

MICS	Multiple Indicator Cluster Survey (UNICEF)
MLR	Muslim Literacy Rate
MMR	Maternal Mortality Rate
MPND	Ministry of Planning and National Development, Maldives
MS	Mahila Samakhya – a women's empowerment and education programme of the Government of India
NAR	Net Attendance Ratio
NER	Net Enrolment Ratio
NFE	Non-Formal Education
NFHS	National Family Health Survey
NNMR	Neo-Natal Mortality Rate
NSS (India)	National Sample Survey
NWFP	North Western Frontier Province of Pakistan
OBC	Other Backward Classes – a category denoting socially disadvantaged groups (castes) in India
PESP	Primary Education Stipend Programme
SC (India)	Scheduled Caste – a socially backward / disadvantaged community in India that has been notified in the constitution of India
SRGBV	School Related Gender-Based Violence
SRS	Sample Registration System
ST (India)	Scheduled Tribe – tribal groups notified in the constitution of India
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
Upazila	Sub District (Bangladesh)
VEC	Village Education Committee
WDR	World Development Report (World Bank)
WHO	World Health Organization
Zila or Zilla	District (Bangladesh and India)

SUMMARY

1. Since the early 1970s, people working in the development sector have highlighted the interconnectedness of social and economic development indicators. For example, areas with low infant and child mortality tend to have high literacy and correlation between fertility rates and educational levels. Most recently the link has been made between nutritional status of children and their ability to enter and complete elementary education. Equally, a woman's status in society directly influences her ability to make decisions and exercise choices. At every stage in the life cycle of girls, their status and bargaining power within the family decide their sense of self-worth and confidence.

2. The interlinkages between education, nutrition and health are well documented and it is universally recognized that education improves the flow of knowledge and enables people to make informed choices. Increased educational levels among women are linked to greater control over the immediate environment (family health, nutrition, education of children) and also contribute towards women's empowerment, enabling them essentially to take decisions and negotiate the world around them from a position of strength. Many experts argue that promoting basic education (of at least eight to ten years) can enhance livelihood options. It can also stimulate productivity, thereby reducing the economic vulnerability of poor households. Educated women are more likely to adopt rational nutrition practices and ensure personal and family hygiene. This in turn improves the overall health and nutritional status of their children. Recognizing that women

share a major burden of work and acknowledging their contribution to ensuring the survival of their families, it is argued that education of girls is an important and critical investment.

3. The potential benefits of girls' education have received far greater attention in the last ten years, partly because of the devastating impact of the global HIV/AIDS epidemic. With its arrival in South Asia, there has been a renewed plea to ensure that all girls have access to basic education as the surest vaccine against ignorance and risky behaviour.

4. Research studies and experience of women's empowerment programmes on the ground in South Asia give out one strong message: *Formal education alone is not adequate to empower women and neutralize the accumulated distortions of the past*. The content of education, the context in which it is imparted and the 'intangible' inputs are all equally important.

5. While economic disparities and social inequalities are certainly important, cultural beliefs and practices and regional characteristics also play an important role in mediating the relationship between education, nutrition, health and empowerment.

6. Another dimension of the lived reality of women and girls pertains to the prevalence of different forms of gender-based violence at home, in school and in society. Gender-based violence is not only confined to home or to intimate spaces with intimate partners. It includes all forms of violence that are linked to gender roles traditionally assigned to sex – from using language that undermines the self-esteem of girls to more horrific situations of rape and sexual harassment – perpetrated, in the case of schools, by teachers or other students. Incidents of school-related gender-based violence (SRGBV) can occur in school or on the way to school or during after-school hours by persons who are teaching or studying with the victim. The pernicious impact of gender violence in school does not affect enrolment and retention alone. It affects a girl's learning, and, often, her whole life. If the victim continues to be in school, she may not be able to learn or may develop a very low self-image. Most importantly, the school ends up reinforcing gender stereotypes, thereby negating the potentially empowering impact of education.

7. **Early marriage and teenage pregnancy** are big issues in the region. A large number of girls are married before the age of 18, and many of them even before they are

15. Similarly, **unsafe abortion** remains an area of concern – especially for those who become pregnant before marriage. The phenomenon of sex-selective abortion has further compounded the problem of early pregnancy and abortion.

8. The **bidirectionality** of the relationship between health and education merits serious consideration and the enormous diversity in social and economic situations in the region makes the relationship between health and education complex and difficult to understand. Families that are economically better off can mitigate the negative consequences of poor health while this may not be so for those living in poverty. In most parts of South Asia, being a girl is a handicap in the first instance. The chances of her receiving additional support from the family or parental investment in the girl child reduce if she is malnourished, ill or disabled. The relationship between health and education is not one-to-one but needs to be located in the larger social and economic context of the family and community.

9. Starting from early childhood, moving to adolescence, and on to adulthood, health affects education in many ways. There is a progression from the infant and child feeding practices, nutritional status and susceptibility to infections of the child (level one) to socio-cultural factors (level four) and HIV/AIDS (level five). Needless to add, each subsequent level affects the prior level:

a. Level one:
- Infant feeding practices, nutritional status and infectious diseases in early childhood / infancy affect school readiness;
- Health and nutrition in early childhood affect enrolment, attendance and learning.

b. Level two:
- Child and family health/illness – in particular susceptibility to infectious diseases like diarrhoea, pneumonia, fevers, measles, chicken pox and other childhood illnesses; and more serious infections like tuberculosis, HIV and AIDS – affect educational participation and outcome.

c. Level three:
- School and community environment, including gender-based violence, affect education outcomes, which adversely affect enrolment, attendance and learning.

d. Level four:
- Socio-cultural perceptions, attitudes and prejudices affect women's and girls' access to services, thereby impacting both health and educational outcomes.

e. Level five:

- HIV/AIDS impacts girls' education in many ways – from increasing workload at home leading to withdrawal from school to discrimination and stigma.

10. All five levels need to be seen in a continuum. In many instances, the cumulative impact of early childhood health and nutrition is exacerbated during the later stages in life. Be it malnutrition, poor health, disease or chronic illness, poor families have to spend on treatment, transport, medicines and so on. These are direct and visible costs. But children, especially girls, bear the real, if indirect, cost. They contribute to the household by working both at home and outside; they look after the ill members and younger siblings, besides helping their mothers in household work. They either absent themselves from school if they attend one or put in long hours before and after school. The real cost of illness and poor health is not only monetary. It is, in fact, built on the sheer lack of choice, in the time that young girls have to spend doing these chores when they should be studying or going to school.

11. That apart, gender disparities are far greater in South Asia than anywhere else in the world. South Asia is the only region in the world where men outnumber women and this deficit stems from lifelong discrimination against girls and women, particularly from inferior nutrition and healthcare that girls receive early in life and during childbearing years. The disparity is not uniform even across South Asia. The situation in northern India, Pakistan and Afghanistan is qualitatively different from Sri Lanka, South India and Bangladesh. Within India and Pakistan, the inequalities vary with region. For example, studies carried out in the region reveal that when children in a household in the northern western belt are ill, more girls have to go without any treatment at all. Gender disparities do not symmetrically decrease with higher income – social and cultural factors influence the status of girls in equal measure.

12. Is South Asia very different from other regions of the world? Does it have some unique characteristics? Poverty, uneven development and historical colonial legacy are not unique to this region. But it is widely acknowledged that South Asia is culturally different, particularly with respect to gender relations. Another significant characteristic of this region is that it has an estimated 400 million young people aged 12–24 – accounting for almost 30 per cent of all young people in the developing world. Close to half of them are girls and women. Therefore unequal gender relations resulting in poor access to education, nutrition and healthcare are bound to affect the overall potential for development.

13. Perusal of country-specific information points to specific concerns and challenges:

a. In **Afghanistan**, security remains a big issue and most of the government efforts are directed towards creating an enabling environment for economic growth and social development.

b. **Bangladesh** has made significant progress in the last ten years on a number of key human development indicators – notably, girls' enrolment, under-five mortality and infant mortality. Government estimates indicate that close to 97 per cent of children (6–10 years) are enrolled in school and the Gender Parity Index (GPI) is 0.97. However, it is noteworthy that while 95 per cent of girls are reported to be enrolled in the 6–10 years age group, this drops to 51 per cent in the 11–18 age group – indicating a high dropout rate. But high levels of poverty and ecological disasters – frequent flooding and land erosion – continue to pose formidable challenges. An important learning from Bangladesh is that purposive policy actions (for example the secondary education stipend programme for girls) can make a difference in a social, cultural and economic environment that is loaded against women and girls.

c. In **Bhutan** over 90 per cent of the population has access to primary healthcare. Sixty-five per cent of people have safe drinking water. The gross enrolment ratio (GER) at the primary level is 72 per cent (boys 82 and girls 62) while the net enrolment ratio (NER) may be as low as 53 per cent (boys 58, girls 47). The government has not only focused on primary education, it has also made efforts in the Ninth Plan to promote vocational and technical education at higher levels and steered a comprehensive policy for sustainable livelihoods for youth in the renewable natural resource sector. This has provided a much-needed momentum to put children through primary and secondary education. Gender-specific information is not readily available, especially regarding the impact of health on education and the overall status of women in society. The dominant perception is that there is no significant difference in attitudes towards boys and girls. The government places the Gross National Happiness of its people above the Gross National Product.

d. **Maldives** is ahead of the other countries in the region in terms of girls' education and health. It is one of the few countries where health is a basic right of every citizen. It stands out in the region in most HDI indicators.

e. In **India** physical access to primary schools has improved considerably since 1990. Gender disparities persist, as do differences between different social groups. Notably the Scheduled Caste (SC – socially disadvantaged groups who were 'untouchable' till this designation was made illegal after India became

independent in 1947) and Scheduled Tribe (ST – indigenous tribes notified in the Indian Constitution) communities and Muslim girls lag far behind when it comes to enrolment and retention in school. Gender and social gaps are significant at the lower secondary level. Malnutrition is another big issue in the country. Health, education and nutrition go hand in hand – it is important to note that areas characterized by low educational participation are also the ones where health, immunization and nutritional status is poor. Gender differences are also more pronounced in areas and communities with poor health, education and nutrition indicators. The intermeshing of high rates of malnutrition, regular bouts of preventable diseases – such as malaria, diarrhoea and respiratory tract infections – severe anaemia and poor health of adolescent girls, and early marriage among the most deprived sections contributes to poor educational as well as health outcomes. Prevalence of corporal punishment and other forms of abuse of children – especially those from deprived social groups and communities – pushes many of them out of school.

f. **Nepal** has witnessed ten years of conflict and is still in a state of flux. Gender differences in Nepal are comparable to India. There are vast regional and social group (caste) differences in educational as well as health and nutritional status. As a new democracy, it may take some time for the government to turn its focus on the health and education of girls.

g. **Pakistan** has been through difficult times in the last decade. War in the region and internal conflict has resulted in a challenging social and political environment, especially for girls and women in the country. The situation is quite similar to its neighbours. Efforts are underway to improve girls' access to education. The HIV/AIDS situation in Pakistan is not yet alarming. Pakistan has a high prevalence of injecting drug users (IDU) – 64 per cent of whom report use of non-sterile needles.

h. **Sri Lanka** has among the best human development indicators in South Asia. For almost six decades the country had free and universal education up to the senior secondary level. Literacy is high and a gender gap virtually absent. But the last two decades have seen a great deal of conflict and violence in Sri Lanka and in the recent past the Tsunami devastated many coastal areas damaging schools, health services and other public services. It is reported that unemployment among women is nearly double that of men even though the status of women here is much better than in most South Asian countries. Notwithstanding the setbacks, most of Sri Lanka has a good public health system and female life expectancy is 74 years.

14. **Recommendations:** The overarching recommendation of this study is to **actively promote a holistic approach to nutrition, sanitation, health, education, violence and socio-cultural issues that influence the overall well-being of girls**. These domains are inextricably intertwined and unless policy makers recognize the importance of looking at them as a continuum, it will not be possible to break out of the vicious circle of deprivation and exclusion. This implies that monitoring indicators used for any of the domains also include indicators from other domains. For example, it is not adequate to gather enrolment and retention data alone. Indicators that capture health status and malnutrition need to be used alongside educational indicators. This is essential for girls – as anaemia, mild to severe malnutrition, worm infections and recurrent bouts of illness affect the ability of girls to pursue their education and benefit from it.

15. Four core programme attributes directly influence access and, hence, the utilization of services pertaining to health and education – **availability**, **range**, **cost** and **quality**. Since health and educational inequity, in turn, is concerned with differential rates of service utilization these make a big difference.

a. Improve health and nutrition of girls:

- Intensify community education and empowerment programmes;
- Enhance the availability of women providers – especially in countries and areas that are marked by sharp gender inequalities and social seclusion of women;
- Move services closer to girls/women – schools, healthcare providers, supplementary nutrition, iron and folic acid supplements, etc.;
- Make services responsive and accountable.

b. Improve the educational status of girls:

- Intensify community education and empowerment programmes;
- Promote community-based structures that can monitor/support schools;
- Appoint women teachers in schools in areas where seclusion is the norm, gender inequalities are severe and girls are withdrawn from school after puberty;
- Improve access to schools right up to the secondary stage – noting that at least eight to ten years of education is essential to bring about significant change in the capabilities of girls to make informed choices and negotiate the world with confidence;

c. Reduce economic barriers by providing free or subsidized services to girls – especially those from poor families/communities:

- Provide subsidized/free education for girls up to the secondary level;
- Make available stipends and scholarships;

- Ensure free or subsidized transportation and residential facilities as required, to enable girls from remote/rural areas to pursue their education;
- Supply nutritious meals in school, textbooks and educational materials; and in the case of older girls provide uniforms;

d. Introduce concrete mechanisms to make the health and educational system accountable and responsive to the needs of girls and women:

- Empower Village Education Committees / Mothers' Committees to supervise, monitor and also provide support;
- Link the education committees to health committees that can monitor, support and supervise;
- Empower habitation level committees / local self-government institutions to play a proactive role in monitoring availability and quality of services.

16. The above interventions need to be initiated and sustained at four levels:

a. Policy and planning levels:

- These comprise legal, regulatory and policy measures, including measures at the macro level, to enhance or re-deploy resources for enhancing gender equity.

b. Programme level:

- This comprises management, including resource deployment and oversight functions.

c. Family and community levels:

- These include 'demand-side' actions for facilitating change in environmental hygiene and the utilization of health services.

d. Service level:

- This consists of the interface at which measures to mainstream gender result in positive outcomes. Actions at the first three levels should lead to outcomes at this level.

17. What is critical in South Asia is to create a nurturing environment for people who are working at the grassroots. It is important to give positive feedback at the right time – disseminating successful experiences, affirmation and friendly and constructive criticism. All these go into sustaining the process long enough for it to leave a lasting impact.

18. This region – like the rest of the world – is used to time-bound projects and programmes. Lasting social change takes time to take root and bring about sustained change. It is, therefore, necessary to take a multi-dimensional view and design interventions that can turn around even the most difficult situation.

1

EDUCATION AND HEALTH OF GIRLS – THE ISSUES AND THE SITUATION

1.1 Introduction

Since the early 1970s, researchers have made a number of connections between different social and economic development indicators. The first of such connections was recognized with research studies showing that countries with low infant and child mortality tend to have high literacy (Bloom, 2005; Bhalla *et al.*, 2003). Recent studies have conclusively shown the short- and long-term impact of undernutrition in children. Poor nutrition in early infancy increases mortality, morbidity and susceptibility to disability. In the long run, early childhood undernutrition can influence adult size, intellectual ability, economic productivity, reproductive performance, metabolic and cardio-vascular diseases (Black *et al.*, 2008; Bryce *et al.*, 2008). Low weight and size of young women in turn leads to complications during delivery and undernourished women give birth to low weight babies.

Researchers pointed out that there was a correlation between fertility rates and educational levels (Subbarao and Raney, 1995). Feminist scholars have challenged this view time and again, arguing for a more holistic approach to women's lives, including their reproductive life. They contend that women's ability to make decisions and exercise choices does not change overnight with literacy or information on contraception. The process of building one's self-esteem and self-confidence is a long process of collective struggle and social transformation. At every stage in the reproductive cycle of the woman, her status and bargaining power within the family decide her sense of self-worth and confidence. Conception, abortion, access

to healthcare, nutrition, rest and recuperation, education, mobility – all these are arenas of conflict and struggle within the family, in society and in politics (Ramachandran, V., 2004).

The complex interlinkages between different human development indicators have long been acknowledged. In particular, modern social epidemiological work on 'gradients in health' has hinted that people with higher social and economic status are healthier and live longer (Schnittker, 2004). Poverty and lower social status can adversely impact the overall physical, educational and social well-being of families. Equally, gender relations have been shown to affect overall educational and health status.

BOX 1: WHAT DETERMINES AUTONOMY OF GIRLS AND WOMEN?

The position of a girl and a woman within the family and in society is determined by the following:

- Sense of self-confidence and esteem.
- Access to resources – economic (income, employment), material (productive assets like land, credit, finance), intellectual (education, knowledge, information).
- Mobility and ability to move beyond her immediate environment for accessing income and knowledge, and gaining self-confidence.
- Personal laws that determine her rights within the family, especially those relating to marriage, divorce, maintenance, inheritance, share of family assets and so on.
- Ability to deal with and redress daily loss of dignity in domestic and societal violence.
- Control over her own labour and income – her ability to determine how she uses her time, demands payment, has control over her income and makes her contribution visible.
- Control over her body and her life – the ability to decide when she gets married, negotiate safe sex within relationships, with whom, and how many children to have and the desired spacing.
- Opportunity to come together as a collective with other women to realize and assert collective strength and fight for rights and demand entitlement.
- Ability to question dominant ideology that justifies subordination in the name of religion, culture and status reproduction.
- Potential to transform existing institutions and gendered spaces in society.

Source: Adapted from Ramachandran, V. (1996).

However, in South Asia, the experience in Sri Lanka, Kerala (India) and Maldives reveals a different trend. Notwithstanding the poverty levels, social policies of governments and good social sector services have made a difference to the educational and health status of even the poorest of the poor. In recent years, Bangladesh and Himachal Pradesh (India) have made impressive progress on child health indicators, and women's education levels have also demonstrated the positive impact of political will and administrative commitment.

The interlinkages between education, nutrition and health have been periodically reiterated. It is almost universally recognized that education improves the flow of knowledge and enables people to make informed choices. The 1990 Jomtien Conference on Education for All and the subsequent global engagement with education have resulted in a wealth of research studies and country-level analyses that demonstrate the positive impact of education on overall development.

This period has also contributed a great deal to our understanding of the linkages between gender equality and other development indicators. In the last ten years a number of gender-related indices have been introduced. For example, the Gender Parity Index is used in education and the Gender Development Index is used in international human development reports. While these are valuable and welcome additions to composite indices, it is important to keep in mind that such composite indices do not always capture the qualitative dimension and also do not take into consideration the broader cultural contours.

Notwithstanding the fact that it has been difficult to establish conclusive causal relationships between different social development indicators (Cutler, 2006), research of the last three decades has shown that gender inequalities are characteristic of communities with poor health, education and development indicators. Conversely, communities that have demonstrated significant progress on health and education fronts are the ones where governments have made concerted efforts to correct gender imbalances in accessing basic social services (like health and education).

Wealth interacts with gender to exacerbate both educational and health outcomes (Filmer, 2000). As Leela Visaria argues, 'The large gender gap prevailing in most countries in the South Asian region in levels of education results in women's powerlessness or non-involvement in decision making at home. Illiterate women are also caught in a vicious cycle of poverty, repeated childbearing and ill-health. At the workplace, women without education are engaged in low-paid, irregular wage employment, work long hours and also face the threat of unemployment. In the public arena, they face indifference or receive scant attention from providers of healthcare and other services …' (Visaria, 2002).

Girls' education has often been positioned as a catalyst that could turn a difficult situation around (Shultz, 1993; Herz and Sperling, 2004; Dreze and Sen, 1999). Increased educational levels among women are linked to greater control over the immediate environment (family health, nutrition, education of children). They also contribute towards women's empowerment, enabling them essentially to make informed choices and also negotiate the world around them from a position of strength. Many experts argue that promoting basic education (of at least eight to ten years) could enhance livelihood options. It also stimulates productivity, thereby reducing the economic vulnerability of poor households. Recognizing that women share a major burden of work and acknowledging their contribution to ensuring the survival of their families, it is argued that education of girls is an important and critical investment.

The potential benefits of girls' education have received far greater attention in the last ten years, partly because of the devastating impact of the global HIV/AIDS epidemic. With its arrival in South Asia, there has been a renewed plea to ensure that all girls have access to basic education as 'the surest vaccine against ignorance and risky behaviour' (Vandemoortlele and Delamonica, 2000).

This paper explores the specific factors and interventions related to women's health (including access to healthcare, HIV and AIDS, STIs and STDs, sexual harassment and violence) that support and enable girls to access, continue and complete basic schooling. The paper locates the arguments in the broader context of the double disadvantages girls and women experience by virtue of belonging to specific social contexts, focus groups / communities, locations and economic backgrounds. The intermeshing of poverty, cultural and social status, gender relations and location is explored with a view to capturing the factors (mainly related to health, violence and HIV/AIDS) that also hinder girls from accessing, continuing and completing basic schooling.

1.2 Barriers To and Benefits Of Girls' Education

'Education is a key factor in sustainable development: it is at the same time a component of well-being and a factor in the development of well-being through its links with demographic as well as economic and social factors. Education is also a means to enable the individual to gain access to knowledge, which is a precondition for coping, by anyone wishing to do so, with today's complex world. The reduction of fertility, morbidity and mortality rates, the empowerment of women, the improvement in the quality of the working population and the promotion of genuine democracy are largely assisted by progress in education.' (UNFPA, 1994, ICPD Programme of Action)

'By providing young women greater economic options and autonomy, education also affords them the knowledge, skills and

opportunities they need to make informed choices about how to delay marriage and child bearing, have healthier babies, avoid commercial sex and other risky behaviours; and gain awareness of their rights.' (UNAIDS, 2005)

Since the 1980s, researchers and practitioners across the world have done a great deal of work on two interrelated issues:[1] (a) barriers to a girl's education; and (b) benefits of a girl's education to the individual, family and society. All studies look at girls' education as a quintessential public good. *Importantly, health emerges as both an important barrier to and a potential benefit for a girl to be able to access and complete basic schooling.*

This realization of the bidirectional relationship of health and education introduces a sense of discomfort into the otherwise optimistic scenario with respect to the benefits and outcomes of education. Research studies and experience of women's empowerment programmes on the ground in South Asia give out one strong message: *Formal education alone is not adequate to empower women and neutralize the accumulated distortions of the past.* The content of education, the context in which it is imparted and the 'intangible' inputs – all of these are equally important. The most palpable reminder in the region of a woman's vulnerability is the continuation of some of the worst forms of gender violence and inequalities, especially sex-selective abortion.

BOX 2: MISSING GIRLS AND WOMEN IN SOUTH ASIA

There are 50 million fewer women in South Asia today than there should be. Girl babies are killed before birth through sex-selective abortions, or die prematurely through violence and neglect. According to the 2001 census, India has only 927 women per thousand men. States such as Punjab, Haryana, Delhi and Gujarat have between 79.3 and 87.8 girls for every 100 boys.

Despite laws against the practice, child marriage is common throughout South Asia, and, effectively, puts a stop to the educational progress of many girls. In Nepal, an estimated 40 per cent of girls are married by the time they reach the age of 15.

The issue of bodily integrity or sexual harassment becomes more urgent and oppressive as a girl gets older. In South Asia, sexual harassment is often referred to by the innocuous-sounding term 'eve teasing', and it is widely reported in Bangladesh, India, Pakistan and Sri Lanka. A girl runs the risk of being harassed, assaulted, abducted, or, even, murdered on the way to and from school, and she is, by no means, free from risk within the school.

Source: Girls' Education in South Asia, Education and Gender Equality Series, Oxfam GB (2006).

The most shocking research in recent times is the evidence from India that shows that education does not prevent women and their families from engaging in sex-selective abortion. The problem of dowry and domestic violence is equally acute among educated families. Gender – as a category – needs to be seen within the larger social, region and location-specific context. South Asia is a region of both rich diversity and sharp disparity – social, cultural and economic. The interplay of socio-economic inequalities and gender relations creates a complex web that either promotes or impedes a girl's ability to go through schooling. If she *does* go to school, gender biases also restrict her movement outside the strict cultural boundaries. Class, caste, ethnicity and tribe exert a great influence on what kind of school she will attend and up to what level she will pursue her education.

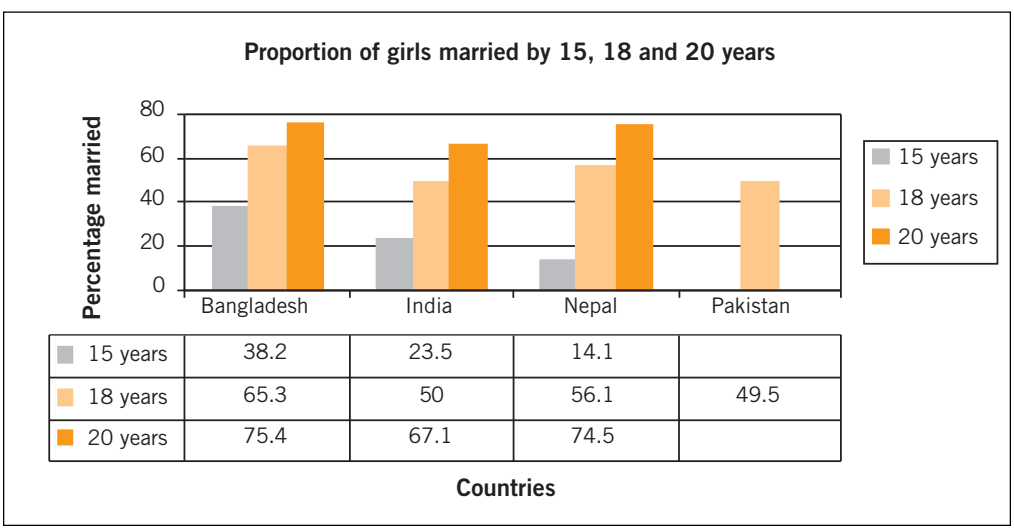
While economic disparities and social inequalities are certainly important, a number of researchers argue that cultural beliefs and practices and regional characteristics play an important role in mediating the relationship between education, health and empowerment (Colclough *et al.* 2000; Jayaweera, 1997; Kumar and Vlassoff, 1999). Jeejibhoy and Sathar (2001) point out that 'the cultures of South Asia are largely gender stratified, characterized by patrilineal descent, patrilocal residence, inheritance and succession practices that exclude women, and hierarchical relations in which the patriarch or his relatives have authority over family members. Levels and patterns of female autonomy vary considerably within the region … region plays the major conditioning role …' The social and educational status of Muslim girls in Maldives, Kerala and Tamil Nadu (India) and Bangladesh is appreciably better than that of Hindus in Rajasthan or Eastern Uttar Pradesh. Equally, the situation of Muslim groups in Baluchistan is considerably different from those in Punjab (Pakistan). Similarly, the social relationships and status of deprived social groups / castes vary with region/state and, even, district. The position of women in different communities and their access to education also differs as we move from one region to the other, one social group to the other, and from urban to rural areas. So do impact and outcomes.

Another dimension of the lived reality of women and girls pertains to the prevalence of different forms of gender-based violence at home, in school and in society. Domestic violence is a worldwide phenomenon. A recent multi-country study carried out by WHO reveals that violence at home, in school and in the larger community is a major public health issue. Gender-based violence is not only confined to home or to intimate spaces with intimate partners. It includes all forms of violence that are linked to gender roles traditionally assigned to sex – from using language that undermines the self-esteem of girls to more horrific situations of rape and sexual harassment – perpetrated, in the case of schools, by teachers or other students (WHO, 2005).

Incidents of school-related gender-based violence (SRGBV) can occur in school or on the way to school or during after-school hours by persons who are teaching or studying with the victim. Both girls and boys are victims of SRGBV. Unfortunately, not many studies have been done on SRGBV in South Asia. A recent report brought out by the Government of India has for the first time highlighted the prevalence of violence in schools (WCD, Government of India, 2006a). The studies emanating from South Asia focus on adolescent reproductive health and rights, sexual violence and abuse. Given the cultural and social fabric of the region, it is difficult for the victim to talk about this violence. But even if she decides to talk about it, it is, more often than not, brushed aside. The pernicious impact of gender violence in school does not affect enrolment and retention alone. It affects girls' learning, and, often, her whole life. If the victim continues to be in school, she may not be able to learn or may develop a very low self-image. Most importantly, the school ends up reinforcing gender stereotypes, thereby negating the potential empowering impact of education.

Early marriage and teenage pregnancy are big issues in the region. An overwhelming number of girls are married before the age of 18, and many of them even before they are 15 (see Figure 1.1). A qualitative study carried out in poverty households of India reveals that the age of marriage is much lower among the very poor (Ramachandran, V., 2004). Similarly, recent studies done in

Figure 1.1 Proportion of Girls Married by 15, 18 and 20 Years



	Bangladesh	India	Nepal	Pakistan
15 years	38.2	23.5	14.1	
18 years	65.3	50	56.1	49.5
20 years	75.4	67.1	74.5	

Source: Santhya and Pachauri (2004)

India also reveal that **unsafe abortion** remains an area of concern – especially for girls who become pregnant before marriage (Visaria and Ramachandran, V., 2007). The phenomenon of sex-selective abortion has further compounded the problem of early pregnancy and abortion (Patel, 2007).

HIV/AIDS has introduced another dimension to the health risks of girls across the world. Unfortunately, the issues of sexually transmitted diseases and the specific vulnerability of women are still not discussed openly, given the specific social, cultural and religious fabric of this region and early marriage. A recent study in India showed that nearly 90 per cent of infected women got the infection from their husbands – with many of them infected at a very young age (ILO, 2003). Notwithstanding the commendable work done in this region on HIV/AIDS in the last decade, gender relations put girls and women at greater risk. Education has the potential to empower them to not only make informed decisions but also to give them the confidence to say 'no'. Yet, due to the manner in which education is transacted and the resistance to reproductive and sexual health education in the region, governments and civil society groups are compelled to address the issue indirectly.

Existing data sets / indicators used in the region do not capture the complex ground realities of South Asia. It is important here to understand the interplay of poverty, social inequalities, cultural practices/norms, religious, caste and gender relations on the one hand and the institutional structures for education on the other. They intersect in different ways in different regions – with one reinforcing the other in some places and offsetting it in others. Understanding and unravelling this crisscrossing mesh is a big challenge (Kabeer and Subrahmanian, 1999). There are, therefore, no simple answers to understand and crack the complex interlinkages between education and health of girls in South Asia.

For a visual summary of this section, see the diagram **Girls' Education: Barriers and Potential Benefits** attached at the end of this paper.

1.3 How Health Affects the Education of Girls

> ***'Intuitively there are reasons to expect that health and education improvements work in tandem … The theoretical channels from improved health to better education vary in nature over the course of an individual's life. Having good health as an infant enhances cognitive development, so healthy children derive greater benefits from schooling. When children reach school age, good health means they can attend school more frequently and pay better attention in class … Healthy siblings and parents alleviate the pressure on older children to assume caretaker roles at home … Just as good health can strengthen education, bad health can weaken it …' (Bloom, 2005)***

For several decades now, the impact of education on the overall health and well-being of children and adults has been established quite convincingly. The impact of health on educational attainment is also flagged. However, the *bidirectionality* of this relationship merits serious consideration, especially within different social and economic levels. These socio-economic differences make the relationship between health and education complex and difficult to understand. For example, families that are economically better off can mitigate the negative consequences of poor health. The same may not be true for families living in poverty (Jackson, 2007). Then, being a girl is often a handicap in the first instance. The chances of her receiving additional support from the family or parental investment in the girl child reduce if she is malnourished, ill or disabled (Ramachandran, V., 2004). The moot point is that the relationship between health and education is not one-to-one but needs to be located in the larger social and economic context of the family and community.

Another important issue that frames the lives of girls is menarche. Natural biological processes of menstruation affect the ability of girls to continue in school – especially where there are no toilet facilities and where there are social restrictions on the mobility of post-puberty girls. Lack of access to facilities for maintaining menstrual hygiene could also enhance the risk of reproductive tract infections.

The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease'.[2] This definition is now widely accepted and has created a framework to take a holistic view of health. So, in what ways do health and wellness influence the ability of children to enrol, learn and complete at least eight years of elementary education? What are the aspects of health that are critical to girls?

Starting from early childhood, moving to adolescence, and on to adulthood, health affects education in many ways. There is a sort of progression from the immediate health situation of the child (level one) to socio-cultural factors (level four) and HIV/AIDS (level five). Needless to add, each subsequent level affects the prior level.

Level one:

- Health and nutrition in early childhood affect school readiness
- Health and nutrition in early childhood affect enrolment, attendance and learning

Poor health and malnutrition can adversely impact school readiness of children. Their health and nutritional status may also directly affect their probability of enrolling in school (Filmer, 2003; Jukes, 2006). This is particularly true of South Asia, which is reported to have among the most alarming child

development indicators. Eminent nutritionists and child development specialists are all unanimous about the need to tackle undernutrition on a war footing. There is almost complete agreement across different stakeholders in South Asia that while income-poverty rates have declined there is compelling evidence to show that nutritional status of people – especially women and children – has remained a major cause of concern (Lancet series on maternal and child undernutrition; see Black *et al.*, 2008; Bryce *et al.*, 2008). For example, data on time trends in poverty ratio and energy consumption computed from NSSO, India consumer expenditure surveys reveals that decline in poverty is not associated with an increase in the energy intake. Over the last three decades food grain availability improved significantly and prices also came down for below-poverty-line families. Even so, 'consumption poverty' continues to be high – with wide state-wise variations within India. Therefore experts argue that the decline in energy intake is not only due to problems in access or affordability of the food (Ramachandran, P., 2008; Ghosh, 2006; Saxena, 2008).

Equally, recent evidence-based research studies reviewed clearly bring out the critical importance of the first two years in the life of children as the health and nutritional status in these formative years have a long-lasting impact on physical and intellectual (cognitive) development of children[3] (Lancet series on maternal and child undernutrition; see Black *et al.*, 2008; Bryce *et al.*, 2008). In April 2007 the Prime Minister of India said '*A number of reports and surveys, including the National Family Health Survey (NFHS-3) ... seem to indicate a noticeable decline in the qualitative aspects of the [ICDS] programme. There is strong evidence that the programme has not led to any substantial improvement in the nutritional status of children under six. Our prevalent rate of under-nutrition in this age group remains one of the highest in the world.*'[4] (See Annex, Tables A.2 and A.3.)

MESSAGES FROM *LANCET* SERIES ON UNDERNUTRITION[5]

- Maternal and child undernutrition is the underlying cause of more than one-third (3.5 million) deaths, 35 per cent of the disease burden in children less than 5, and 11 per cent of total global disability-adjusted life-years (DALYs). Deficiency of vitamin A and zinc is responsible for 1 million deaths; iron and iodine deficiencies are responsible for fewer child deaths. Suboptimum breastfeeding is responsible for 1.4 million child deaths and 44 million DALYs.
- Poor foetal growth or stunting in the first two years of life leads to irreversible damage, including shorter adult height, lower attained schooling, reduced adult income, and decreased offspring birth weight.
- Pregnancy to age 24 months is the golden interval for nutrition interventions; after age 2 years, undernutrition causes irreversible damage for future development towards adulthood; early brain development also requires environmental stimulation – inadequate cognitive or social stimulation in the first 2–3 years has lifelong negative consequences on educational performance and psychosocial functioning.
- Children who are undernourished in the first 2 years and who put on weight rapidly later in childhood and adolescence are at high risk of chronic diseases related to nutrition.
- There are proven effective interventions to reduce stunting and micro-nutrient deficiencies: breastfeeding counselling, vitamin A supplementation, and zinc fortification have the greatest benefits.
- Long-term investments in the role of women as full and equal citizens through education and economic-social-political empowerment will be the only way to deliver sustainable improvements in maternal and child nutrition, and improved health.

Source: Summarized from Lancet Series on Maternal and Child Undernutrition, Lancet, 2008.

The fundamental problem that the South Asia region is confronted with is persistence of high levels of child malnutrition – as measured using three indicators (see Table 1.1) – 'underweight reflecting in low weight for age, stunting, a chronic restriction of growth in height indicated by low height-for-age and wasting, an acute weight loss indicated by low weight-for-height and less visible micronutrient deficiencies.'[6] Furthermore, the problem of undernutrition is

exacerbated by poverty, non-availability of healthcare services, unhygienic living conditions, lack of access to safe drinking water and poor sanitation. Equally, these very social development factors also become an important determinant of persistent undernutrition among children. There is today compelling evidence to show the interconnectedness of poverty, living conditions, food and income security, access to water and sanitation and education (of children and mothers). It is in this context that organizations committed to child rights and development have to bring this issue centre-stage in their ongoing work.

Table 1.1 Basic Child Nutrition Indicators, South Asia

	Under 5 mortality		IMR		NNMR	% LBW	Underweight (2000–2006)		Wasting	Stunting
	1990	2006	1990	2006	2000	1999–2006*	Moderate + severe	Severe	2000–2006	
Afghanistan	260	257	168	165	60	–	39	12	7	54
Bangladesh	149	69	100	52	36	22	48	13	13	43
Bhutan	166	70	107	63	38	15	19	3	3	40
India	115	76	82	57	43	30	43	16	20	48
Maldives	111	30	78	26	37	22	30	7	13	25
Myanmar	130	104	91	74	40	15	32	7	9	32
Nepal	142	59	99	46	40	21	39	11	13	49
Pakistan	130	97	100	78	57	19	38	13	13	37
Sri Lanka	32	13	26	11	11	22	29	–	14	14
South Asia	123	83	87	62	44	29	42	15	18	46

Source: UNICEF State of the World's Children, 2008

	Vitamin A supplement coverage rate (6–59 months) 2005		% of households consuming iodized salt
	At least one dose (%)		
Afghanistan	95	91	28
Bangladesh	83	82	84
Bhutan	–	–	96
India	64	64	51
Maldives	–	–	44
Myanmar	95	95	60
Nepal	96	96	63
Pakistan	95	95	17
Sri Lanka	64	61	94
South Asia	71	71	51

Source: UNICEF State of the World's Children, 2008

Undernutrition is a cumulative result of a range of factors, namely:

a. **Birth weight, infant care and feeding:** Birth weight and the health of the mother during pregnancy and lactation; introduction of breastfeeding immediately after birth and exclusive breast feeding up to 6 months and frequent feeding of supplementary food (solids and semi-solids) from 6 months to 36 months. Since the mid-1970s the importance of proper infant care and feeding has received focused attention across the world.
b. **Prevention of communicable diseases:** Notwithstanding the birth weight and feeding practices, frequent bouts of diarrhoea or fever, measles and other childhood illness can exacerbate poor nutritional status and set in motion a vicious cycle where malnourished children become more susceptible to infections. Full immunization, safe water, proper sanitation and family and personal hygiene of the mother and other family members are known to make a huge difference.
c. **Timely and rational management of childhood illnesses:** The governments in the region and UNICEF have focused on the importance of rational management of childhood illnesses – like making available ORS for diarrhoea management, proper nutrition and timely medical help. Equally, providing vitamin A supplement and iodized salt have also been promoted across the region.
d. **Persistent poverty, seasonal food shortages and hunger and workload of mother:** The fourth determinant of nutritional status of children is poverty and availability of food either through the year or during lean seasons coupled with increased workload of mothers engaged in wage labour and lack of time or other resources to care for the infant and child.

In turn, undernutrition further reduces the ability of children to fight infections and recover. A conceptual framework is now available to unpack and understand the situation. The first – which has been developed by UNICEF[7] – 'malnutrition and child death are viewed as two of the manifestations of a multisectoral development problem that can be analysed in terms of the immediate, underlying and basic causes. The immediate causes are inadequate dietary intake and infectious disease; the underlying causes are household food insecurity, inadequate maternal and childcare and inadequate health services and health environment; the basic causes include formal and non-formal institutions, political and ideological superstructure, economic structure and potential resources. Although more refined versions of this framework have since been developed (e.g. adding female education just below the underlying causes and distinguishing human, economic and organizational resources), all of them contain the basic elements shown [see Figure 1.2] ... In this framework malnutrition is viewed as

one important *manifestation* of a larger development problem. The framework does not imply that food, health and care are inadequate in all settings – but that these three define the full range of possibilities and the relative importance of each must be assessed and analysed in each setting in order to define priorities for action ... The overlapping circles among Food, Health and Care in the figure are meant to imply that these three are related to each other in complex ways, which must be analysed and properly understood in a given context in order to design appropriate actions. For instance, food secure households may still contain malnourished children because the burden of women's agricultural and other work (as well as other factors such as inadequate caretaker knowledge) may compromise the quality of childcare ... This framework emphasizes the importance of developing a sound understanding of the causes of malnutrition in a given setting in order to design appropriate actions' (UNICEF and World Bank, 2002).

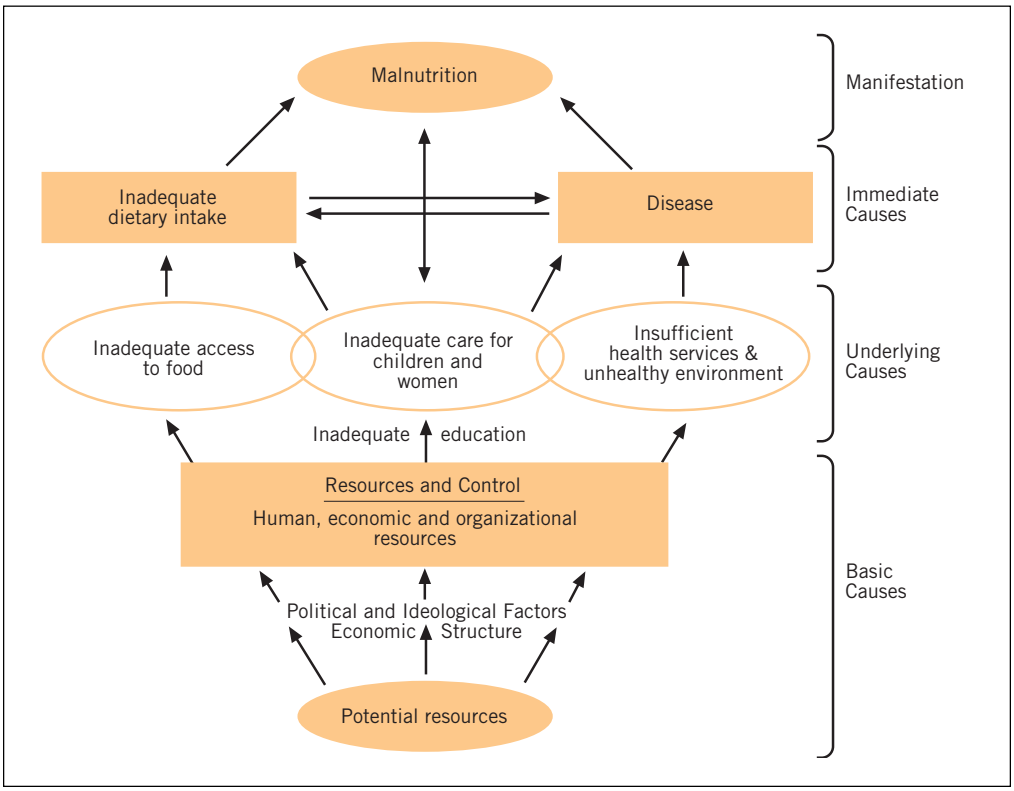
This approach essentially calls for action at all three levels – firstly at the household level with women and children by improving childcare and feeding practices, secondly at the community level to improve the overall hygiene, sanitation and the immediate environment in which children live and also access timely healthcare services, and finally it also makes a case to enhance access to supplementary food for children in diverse poverty situations.

This framework recognizes that the interplay of the three domains needs to be understood in a holistic manner – and argues that the larger political / economic and 'ideological' factors determine the commitment of governments/administrations to make a difference. This perhaps explains the wide inter-state variations that are evident (as discussed in preceding sections above).

The more nuanced version of the framework can be used to integrate women's education and women's status relative to men (for both food security and care). There is considerable global evidence to show that women's education and women's status has one of the strongest impacts on child malnutrition – as the quantity of food available increases, girls are fed as well as boys and, most importantly, maternal nutrition and health also receive attention (Smith and Haddad, 1999).

Once children are in school, poor health, infections / communicable diseases, hunger and malnutrition affect their ability to be regular at school, be attentive in class and to learn. In other words, these factors essentially shape their cognitive ability or capacity to learn. As already mentioned above, for a child to be a girl adds yet another dimension to the adverse impact of these factors. Girl children, especially in South Asia, may not have the same access as their brothers to healthcare, proper nutrition and emotional care.[8] In Afghanistan, Bangladesh, India and

Figure 1.2 UNICEF Conceptual Framework for Malnutrition (UNICEF, 1990)



BOX 3: BEFORE SHE REACHES SCHOOL

Before children reach school age they must negotiate threats from a number of diseases. More than 50 per cent of child deaths are caused by pneumonia, diarrhoea, malaria, measles, malnutrition and HIV. Health and nutrition can affect education in many ways. In resource-poor countries, physical and mental disability can be a major barrier to schooling … school readiness depends on cognitive, motor and socio-emotional development which can be affected by, among other things, undernutrition, iron deficiency, anaemia and malaria. For malnourished children, psychosocial stimulation can be as effective as nutritional supplementation in compensation for delayed cognitive development.

Source: Jukes (2006).

Nepal, the male–female differentials (and rural–urban differentials) in nutritional status of under-five children is fairly significant (see Annex, Table A.3).

Nutritional deficiency may impede the ability of children to learn. Vitamin A deficiency (leading to partial or total blindness) not only affects their ability in class because of poor eyesight, but also increases the risk of infections like measles and other childhood illnesses. Iodine deficiency, anaemia and other vitamin deficiencies are also known to affect their health and make them physiologically vulnerable. For example, walking a short distance to school may become difficult for an anaemic child because of fatigue or shortness of breath. Studies have also found that stunting (low height for age) partly delays enrolment because of parental perception of the suitability of these children for schooling. Stunting is known to affect girls' enrolment more than boys' (Jukes, 2006).

Nutritional deficiencies, which cause learning problems for children at school, also cause them to drop out. As a result, the school-feeding programme was universalized in India in 2001. Studies completed in different parts of the country in India reveal a positive impact of the meal programme on girls' enrolment and attendance (Government of India, 2006b). Persistence of social discrimination in the supply of meals in schools in some parts of India marginalizes children of specific social groups, like Dalits. Within the Dalit community, this discrimination may affect the education of the girl children more than the boys.

Level two:

- Child and family health/illness (including tuberculosis, HIV and AIDS) affect educational participation and outcome
- Menstruation and need for toilets, safe menstrual hygiene practices (like sanitary napkins) and need for iron supplements (to address anaemia) affects older girls

In the last three decades there has been a fair amount of cross-disciplinary work on the interlinkages between child health, education and gender relations. Way back in 1978 WHO and UNICEF turned the spotlight on the importance of immunization and the prevention of endemic diseases as an important and inalienable part of child development. Equally significant was the 1980s when the devastating impact of unequal gender relations on the wellbeing of women and their children was also flagged by UNICEF. Notwithstanding these commendable efforts in the region, by 1990 WHO estimated that 'at least 200 million children aged 5 years fail to reach their potential in cognitive and socio-emotional development because of four causes: malnutrition that leads to stunting, iodine and iron deficiency and inadequate stimulation in the first five years of life' (Jolly, 2007). When this is further compounded with frequent bouts of illness, susceptibility to diarrhoea due to poor sanitation and lack of access to

DETERMINANTS OF CHILD MORBIDITY AND MORTALITY

WHO estimates that children under 15 years of age contributed 36 per cent of total loss of years of healthy life globally in 2002, while children under 5 years accounted for 90 per cent of these deaths. A large proportion (60%) of these deaths is related to communicable and vaccine preventable diseases … The persistently high burden of diphtheria and whooping cough in the region reflects the poor ability of health systems to deliver vaccines …

The immediate causes of high rates of poor maternal and child health in South Asia, however, are underlaid by more basic determinants. These include the poor status of women in society and the roles of poverty, illiteracy and social inequity. Sri Lanka remains a remarkable exception as a result of the large and sustained investments it has made in providing primary healthcare and education to its population. This is especially reflected in the status of maternal health, with almost 94 per cent of births in Sri Lanka attended by skilled health workers. In contrast, 64 per cent of women in India do not receive any form of antenatal care and only 18 per cent deliver in health facilities.

This 'feminization of poverty' in South Asia is a fundamental anomaly that has impaired social development in the region. Sex inequity in health indictors is an almost universal phenomenon in the region and is evident in care-seeking practices, referral patterns, and mortality indicators. In particular, recent demographic shifts in the population in north India indicate an unrecognized but important effect of abortion of female foetuses since ultrasonography became generally available in pregnancy.

These social barriers to development are compounded by the lack of safety nets and dysfunctional health systems that fail to provide basic services at grass-root levels. In most instances widespread corruption, relatively centralized health policy making, and poor devolution to local governments lie at the core of the problem.

In some parts of South Asia, these social issues have been compounded by conflict and upheaval. The war in Afghanistan spanning 25 years, the Maoist uprising in Nepal, smouldering civil war in Sri Lanka, and the longstanding feuds between Pakistan and India have had huge impacts on the lives of people in the region. Though the war in Afghanistan had a direct effect on child mortality and displacement of large sectors of the population, the disruption of families and forceful conscription as child soldiers in Sri Lanka's civil war has been equally disastrous. These children of war have the makings of a future generation that is at great risk of social dysfunction and impaired psychological development.

Source: Bhutta et al. (2004).

safe water, childhood illnesses like measles, scabies and other skin conditions, worm infections etc., then the child's ability to participate in schooling goes down drastically. When this is further compounded by unequal gender relations – where girl children receive little or delayed medical attention, then mortality among girls goes up.

Illness in the family or illness of children may prompt parents to withdraw their children from school, particularly girls who take care of ill adults or siblings. The stigma attached to children from families affected by HIV/AIDS further pushes them out of school. Attitudes and prejudices of teachers, other children and parents (of other children) are also known to discourage children from continuing in school. Human Rights Watch (September 13, 2005)[9] documented the devastating effect of the global HIV/AIDS pandemic on children's right to education, particularly for the estimated 14 million children worldwide who have lost one or both parents to HIV/AIDS. Both in sub-Saharan Africa, where the crisis is most acute, as well as countries like India and Russia, Human Rights Watch found that children affected by HIV/AIDS may be denied access to school or be mistreated by teachers. Many children, particularly girls, are pulled out of school to care for family members who are ill, or are forced to work to supplement their family's income when a parent falls ill or dies. A stressful family environment may also lead to children dropping out of school (Wijngaarden and Shaeffer, 2005).

Childhood malaria – resulting in frequent fevers and weakness, lack of resources for medication or even prophylactic drugs to prevent malaria in highly vulnerable areas – is known to affect the ability of children to continue in school. A global study that followed children who

PNEUMONIA: THE FORGOTTEN KILLER OF CHILDREN

The 2008 *State of the World's Children* has forced the attention of the world on pneumonia, which kills more children that AIDS, malaria and measles combined. Children weakened by other illness or undernourished are at greater risk of getting pneumonia. Thankfully as a large proportion of severe pneumonia cases are bacterial in origin they can be easily treated with antibiotics – provided children are taken to a doctor or hospital.

Unfortunately, given prevalent gender relations, boys are more likely to be taken for treatment at an early stage. Community-based care is possible – provided a programme (like in Tanzania) is launched with adequate support from the health system.

Source: State of the World's Children 2008 (UNICEF), p.10.

were given preventive drugs up to 15 years shows that the administration of the drugs positively impacts the ability of children to remain in school, particularly of girls whose chances to do so double (Jukes, 2006). This is of great value in South Asia where malaria is endemic. Similarly, meningitis (inflammation of the protective lining around the brain and spinal cord) is reportedly prevalent in many South Asian countries. Recently in parts of Uttar Pradesh (India), hundreds of children died of meningitis.

Withdrawal of post-pubescent girls from schools and the effect of lack of separate toilets, sanitary napkins and iron supplements is known to affect the ability of girls to continue their education.

Level three:

- School and community environments affect education outcomes, including gender-based violence that adversely affects enrolment, attendance and learning
- Prevalence of gender-based violence makes older (post-pubescent) girls at greater risk of dropping out or being pulled out of school

Gender-based violence is an extremely sensitive issue. It is deeply rooted in cultural attitudes, practices and value systems. It has a range of negative consequences in the lives of children, especially girls. Many areas in Afghanistan, Nepal, Sri Lanka, Pakistan and India have experienced

BOX 4: GENDER-BASED VIOLENCE AGAINST CHILDREN

- Child abuse: physical violence and sexual abuse at home and school, on streets and other public places.
- Violence in the community/region: communal, religious, social – children affected physically, emotionally and psychologically.
- Psychological and emotional violence.
- Child marriage.
- Child prostitution and trafficking.
- Corporal punishment – verbal, physical and psychological.
- Domestic violence directed straight at children or violence against mother in the presence of children.
- Homicide of children in the streets.
- Acid attacks on girls.
- Honour killing – young girls affected in some regions of South Asia.
- Armed conflict and political violence – children affected physically, emotionally, psychologically.

Source: Compiled by the author.

violent conflict, war and social unrest. The negative impact of violence, conflict and war on the education of girls has been demonstrated (Aikman and Unterhalter, 2005; WHO, 2005). Gender-based violence is also inextricably linked to HIV/AIDS. In addition, the big cities in South Asia are also known to have a large number of street children, who are at particular risk of sexual abuse and violence.

Natural disasters also affect children's education. Displacement due to floods/ earthquakes, for example, and other ecological calamities known to lead to large-scale migration disturb the education of children, particularly of girls who end up sharing the major load of domestic work that includes looking after siblings. These can lead to psychological distress, permanent physical disability and long-term mental ill health.

Level four:

- Socio-cultural perceptions, attitudes and prejudices affect women's and girls' access to services, thereby impacting both health and educational outcomes

Caste/community discrimination is a particularly culture-specific issue in many parts of South Asia. This inequity pervades health facilities, schools and almost all public spaces. Children from specific social groups may be more vulnerable to violence – verbal and physical abuse, neglect and also denial of access to water and food, etc. For example, the PROBE Report (1999) found that in India upper caste teachers humiliated children from Dalit (erstwhile 'untouchable') and tribal communities by labelling them dull and incapable of learning. Girls are doubly disadvantaged when caste and community-based discrimination is compounded with gender discrimination.

Children with disabilities (mental, visual, audio and orthopaedic) face greater challenges. Given the gender relations in South Asia, parents may not go out of their way to find and provide appropriate educational opportunities for girls. Schools may not have the resources (human and physical) to address the needs of children with disabilities or chronic illnesses. While governments across the region are now sensitive to the education needs of 'differently abled' children, the region has a long way to go before inclusive education becomes a norm rather than an exception. What is significant in the South Asian region is that girls with disabilities bear a double burden – of being a girl and being disabled. This affects their health, education and, even, survival.

Level five:

- HIV/AIDS impacts girls' education in many ways

HIV/AIDS can potentially impact access to, demand for and delivery of education. As already mentioned, children with HIV or children of infected parents may be at the receiving end from both the school and the community. This segregation is

BOX 5: STANDING EDUCATION ON ITS HEAD!

The world has not been the same since HIV/AIDS made its first appearance in the late 1970s and early 1980s. Neither can education be the same. Yet there has been very little recognition of this change. The existing response to the way the epidemic interacts with education, especially through the schooling system, has been piecemeal. There has been considerable tinkering around the edges. But this has not been accompanied by great efforts to re-examine education in its entirety, or to ask whether, as currently conceived and provided, education can meet the expectations that it be a potent force for gaining control over HIV/AIDS.

Education in a world with AIDS must be different from education in an AIDS-free world. The content, process, methodology, role and organization of school education in a world with HIV/AIDS must be radically altered. The entire educational edifice must be dismantled. Every brick must be examined, and, where necessary, re-shaped before it is used in a new structure that has not yet been designed.

Source: Kelly (2000).

particularly severe when the HIV/AIDS threat is new to a society (as is the case in many parts of South Asia where we still do not have complete information on the extent of the infection; see Annex, Table A.6) and before the society comes to grips with it. Girls, however, may be affected far more than boys. A stressful family environment may also lead to children dropping out of school (Wijngaarden and Shaeffer, 2005). This poses a huge challenge to educators across the world.

Education may be the best 'vaccine' to empower young people so they can make informed choices. 'In education, it can no longer be business as usual – it can no longer be education as usual. Education can, and will, never again be the same. Its overall purpose – to prepare individuals to live harmoniously, constructively and happily as members of local, national and international communities – remains unchanged. But the ways of achieving this purpose in a world with AIDS are very different from what they were in a world without AIDS' (Kelly *et al.*, 2004). The epidemic has also raised important curriculum-related issues: skills education / sex education and the need to deal with stigma and discrimination. All of these are sensitive issues in most of South Asia.

In the last five years there is a realization that higher levels of education can positively influence risk perception among young people, especially women. This is particularly

BOX 6: EDUCATION AND HIV/AIDS

- HIV is spreading fast among women, who constitute 38 per cent of people with HIV/AIDS (Oxfam GB, 2006), and it is spreading among teenage girls; however, the Global Monitoring Report 2007 (UNESCO, 2007a) estimates that 28.6 per cent of those infected by HIV (age 15+) in India are women and in Nepal 21.6 per cent. The percentage of those infected in Pakistan who are women is 16.7 and in Bangladesh 12.7.
- Almost half of the adults living with HIV and AIDS today are women. According to UNAIDS, over the past few years the number of women and girls infected with HIV has increased in every region of the world, with rates rising particularly rapidly in Eastern Europe, Asia and Latin America. In sub-Saharan Africa, women and girls already make up almost 60 per cent of adults living with HIV.
- While, globally, countries that are not on track for achieving Universal Elementary Education (UEE) are also the worst affected by HIV/AIDS, we do not have accurate estimates for all the South Asian countries.
- During the later stage of the epidemic (as it is now), information available can enable women to protect themselves by changing their behaviour and mitigate the socio-economic factors that put them at risk in the first place.
- Educated girls have a greater chance of protecting themselves through knowledge, delayed marriage and sexual activity, and greater self-esteem and confidence.
- Education helps women protect themselves by improving their risk perception and reducing risky behaviour. This could enhance their ability to discuss sex with their partners and negotiate behaviour (including use of condoms).
- School-based education programmes should become broadcasters of age-appropriate information to change behaviour. However, this may not be easy in most South Asian countries as political and religious leadership continues to resist efforts to introduce sex education in schools or even in non-school-based programmes for adolescents.
- The 'good woman' ideology in South Asia persuades women to stay ignorant about sex and be passive in sexual interactions. This, coupled with traditional norms of virginity, the stigma against seeking help for STIs and women's economic dependency, put women at risk.
- Education – at least eight to ten years of it – can make a difference provided it enables women to critically reflect on their life situation and make rational and informed decisions.

Source: Compiled by the author from several sources.[10]

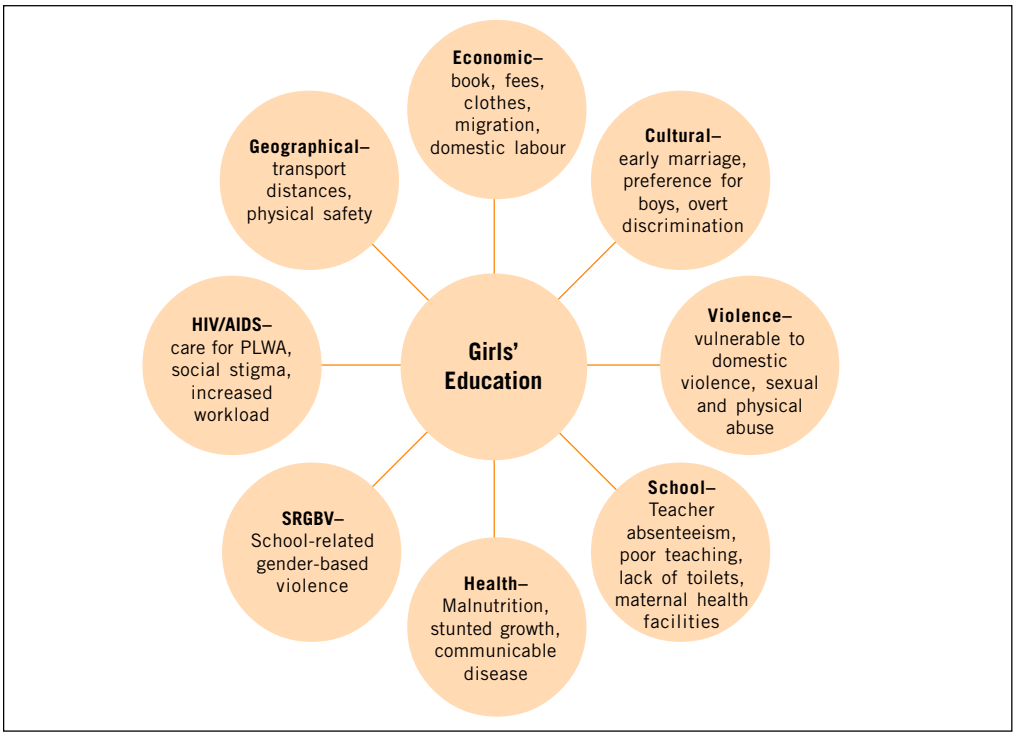
true in South Asia where a large proportion of girls in rural/remote areas and among some social groups/ communities get married when they are still in early adolescence.

Figure 1.3 summarizes the barriers faced by girls in accessing and completing 8–10 years of education.

Cumulative impact of the five levels

All five levels need to be seen in a continuum. In many instances, the cumulative impact of early childhood health and nutrition is exacerbated during the later stages in life. Be it malnutrition, poor health, disease or chronic illness, poor families have to spend on treatment, transport, medicines and so on. These are direct and visible costs. But children, especially girls, bear the real, if indirect, cost. They contribute to the household by working both at home and outside; they look after the ill members and younger siblings, besides helping their mothers in household work. They either absent themselves from school if they attend one or put in long hours before and after school. The real cost of illness and poor health is not only monetary. It is, in fact, built on the sheer lack of choice, in the time that young girls have to spend doing these chores when they should be studying or going to school (World Bank, 2004).

Figure 1.3 Barriers Faced by the Girl Child in Accessing and Completing 8–10 Years of Education



POSITIVE PRACTICES CAN BREAK THE CYCLE

- Enough food and the right kinds of food through improved feeding practices and nutrition education and support
  - Chronically undernourished
  - Nurturing newborns
- Nutritional needs of young infants / children through improved practices, education and support
  - Breastfeeding
  - Complementary foods at the right age
  - Continuous feeding during diarrhoea
- Protecting children from infections
  - Immunization against common childhood diseases
- Diarrhoea prevention and management
  - Safe water – harvesting, disinfection, treatment, purification, storage
  - Hygiene and sanitation facilities
  - Quality care when children fall ill
  - Education programmes for health-care providers
- Micronutrient deficiencies
  - Iodized salt, iron and folic acid given to women, adolescents and children, vitamin A, zinc
  - Kitchen gardens to grow local fruits and vegetables and continuous and sustained education about micronutrients
- School based interventions
  - School feeding programme – mid-day meal
  - School health programme, health and hygiene education
  - Safe water in school, education of children about water borne diseases
  - Toilets for all children – especially for girls and women teachers
- Nutritional support and education for adolescent girls and women
  - Chronically undernourished women tend to bear low-birth weight babies; stop the vicious cycle of undernutrition into the next generation

That apart, gender disparities are far greater in South Asia than anywhere else in the world.[11] South Asia is among the few regions in the world where men outnumber women and this deficit 'stems from lifelong discrimination against girls and women, particularly from inferior nutrition and healthcare that girls receive early in life and during childbearing years' (Visaria, 2002). In fact, the disparity is not uniform even across South Asia. The situation in northern India, Pakistan and Afghanistan is qualitatively different from Sri Lanka, South India or even Bangladesh. Within India and Pakistan, the inequalities vary with region. For example, studies carried out in the region reveal that when children in a household in the northern western belt are ill, more girls have to go without any treatment at all.

Gender disparities do not symmetrically decrease with higher income levels either. 'Benign neglect is what girls are subject to at all ages in South Asia. This neglect may take the form of poor nutrition, lack of preventive care (specifically immunization), and delays in seeking healthcare … A girl between her first and fifth birthday in India or Pakistan has a 30–50 per cent higher chance of dying than a boy. Early marriage and pregnancy, anaemia, sexual violence, and poor educational opportunities all contribute to ill health among female adolescents in this region … In most parts of the world, men bear the greater burden of violence and injuries; however, suicide among young women may be more common in South Asia than in other parts of the world. This, combined with the distressing practice of "dowry murder", means that young South Asian women are at a particular risk from violence … education and improved economic circumstances alone are likely to be insufficient to change practices that have become culturally, socially, and, in some cases, legally enshrined' (Visaria, 2002).

It is noteworthy that the situation in China is not dissimilar to South Asia. China's fifth national census showed that the sex ratio at birth was around 116.86 males per 100 females in 2000. The proportion of boys increased after 1980: it was 108.5 in 1982 (the third national census); 110.9 in 1987 (population sample surveys); and 111.3 in 1990 (the fourth national census). The census also showed that Hainan and Guangdong provinces in South China have the most imbalanced sex ratios at birth, at 135.6 and 130.3 respectively.[12]

The manifold and multifaceted nature of the relationship between health and education of girls has been summarized in Table 1.2. The bidirectionality of the relationship needs to be underscored. Health is certainly a critical determinant of the ability of girl children to enrol, attend, learn and complete schooling. At the same time, it is important to acknowledge that at least eight to ten years of schooling can enhance the ability of girls to take greater control of their lives and also exert a positive influence on the health and well-being of their families.

Table 1.2 shows how health affects girls' education. The table is summarized as the diagram **Ways in Which Health Affects Education of Girls** attached at the end of this paper.

Table 1.2 How Health Affects Girls' Education

Health issues	Impact on education
Undernutrition (protein energy and malnutrition)*	- Impairs mental development / cognitive development - On recovery, children remain impaired - Motor development affected - Poor emotional development - Frequent bouts of illness make it worse
Iron deficiency and anaemia	- In infants, it affects psychomotor development - Older children – weak, listless, get tired, irritable, cannot concentrate and susceptible to illness/infections - Gender differences in access to food and medical care - Adolescent girls attaining menarche may not have access to iron and folic acid
Iodine deficiency	- Iodine essential for brain development – mental development affected by deficiency - Hypothyroidism in mother can lead to mental retardation in children
Worm infections	- May lead to weakness / aggravate malnutrition - Affects cognitive development - Hookworm can lead to anaemia
Infectious diseases, tuberculosis, malaria, meningitis, scabies, gastrointestinal infections / diarrhoeal diseases	- Weakness, frequent spells of illness - Cognitive impairment - Skin eruptions / oozing sores – leading to segregation/disgust in school - Long-term behavioural problems (especially with scabies and skin infections)
HIV/AIDS impact on the school	- Teacher attrition / dropout of children of people who are affected – no evidence as yet in Asia of impact of HIV/AIDS on education - Children withdrawn due to stigma, care of the ill - Low teacher attendance/availability in the event of many cases in village/locality - Scepticism regarding the value of education – sense of fatalism - Education system not prepared to deal with it – as yet

HIV/AIDS infection in children / risk of infection	- Poor families with no access to Antiretroviral Therapy (ART) give up hope - Children orphaned and have to take on survival tasks - Children with AIDS are most likely to have lost one or both parents - Increased rates of depression and feeling of helplessness - Social stigma – no support structure
Violence and child abuse**	- Early exposure to violence can have an impact on the architecture of the maturing brain - Social, emotional and cognitive impairment – including substance abuse, early sexual activity, anxiety, depressive disorders, aggressive behaviour - Eating and sleeping disorders - Feeling of shame and guilt - Physical injuries, pregnancy - Reproductive health problems - Attempts to suicide
Corporal punishment, bullying and gender-based violence in schools***	- Affect cognitive development - Child withdraws in school – does not participate - Negatively impacts self-esteem - Lead to dropping out - Feeling of shame and guilt - Physical injuries, pregnancy

** Filmer (2003); Jukes (2006); Lancet Series on Undernutrition (2008)*

*** UNICEF (2007)*

**** UNICEF (2007), Chapter 4*

1.4 Is South Asia Different From Other Regions?

The question that comes to mind is whether South Asia is very different from other regions of the world and whether it has some unique characteristics. Poverty, uneven development and historical colonial legacy are not unique to this region. But it is widely acknowledged that South Asia is culturally different, particularly with respect to gender relations. Adult female literacy at 64 per cent of male literacy is the lowest in the region (see Annex, Table A.4). Equally, other gender indicators in this region are particularly poor. This region has a high population density and per capita income is higher than only Sub-Saharan Africa.

Another significant characteristic of this region is that it has an estimated 400 million young people aged 12–24 – accounting for close to 30 per cent of all young people in the developing world.

This 'demographic dividend' is said to have accounted for a third of East Asia's economic miracle. 'The recent success stories of East and Southeast Asia and Ireland suggest that development requires a combination of factors ... Interactions among the many relevant factors have the potential to set off virtuous development spirals and to halt vicious spirals ...' (Bloom, 2005).

The potential of this dividend is even greater in South Asia. The World Development Report (WDR) of 2007 predicts that this cohort will grow slowly (except in Pakistan) and will peak in the next 25 years. Close to 45+ per cent of these young people are girls and women. Women's participation in decision making is limited not only because of the unique cultural characteristics of this region but also because of high dropout rates after primary school among girls.

In the last few decades rapid economic growth in South Asia has infused a sense of optimism – it could be compared with the economic boom witnessed in East Asia in the 1990s. East Asia has been relatively more stable for several decades now and has experienced rapid economic development as well as good progress in human development indicators. This region has also been seen as being relatively more forward looking – especially with respect to gender relations, women's participation in the workforce and girls' participation in education. South Asia, on the other hand, has experienced social and political conflict, natural disasters and internal strife. What places South Asia apart from East Asia is the persistence of gender inequality. Yet, the potential of exponential economic growth and the promise of accelerated educational development have instilled a sense of optimism and hope. However, as compared with South East Asia, this sub-region has a long way to go before attaining higher human development goals as well as greater gender equality.

Clearly, the region faces formidable challenges. But it also holds out the promise of rapid progress and development. Nobel Laureate Amartya Sen has pointed out time and again that gender inequality is keeping the region back. He believes that if the countries are able to prioritize education, health, nutrition and overall well-being of girls, the region may see unprecedented change.

2

EXPLORING COUNTRY-SPECIFIC TEXTURES

2.1 Afghanistan

Afghanistan is at one end of the developmental spectrum of South Asia. After many years of conflict and war, the focus now is on reconstruction. Insecurity remains a big issue in the country and most of the government efforts are directed towards creating an enabling environment for economic growth and social development (Afghanistan HDR, UNDP Afghanistan, 2004). It is indeed notable that between 2002 and 2004, 4.2 million children returned to school and girls' enrolment went up from a mere 3 per cent before 2002 to 30 per cent in 2003 and 54 per cent in 2006. Notwithstanding this progress, more than 1 million girls aged 7 to 13 years are not in school. As with the rest of South Asia, there are regional differences in Afghanistan too. Out of 34 provinces there are nine provinces where 80 per cent of the girls are not enrolled. The key barriers to accessing education are: distance, safety, lack of 'girls only' schools, shortage of women teachers and social/family attitudes.

The country has, perhaps, one of the worst health indicators, with infant mortality rate (IMR – infant death in the first year of life) at 165 per 1000 live births and child mortality (CMR – death of children in the first five years after birth) at 275 per 1000 live births. Availability of water and sanitation is poor and prevalence of illness and disease is worrisome. The country has the highest maternal mortality rate in the world – 1600 deaths per 100,000 live births (Sondorp, 2005). This, in itself, is an accurate indicator of both the status of women as well as their access to basic healthcare and nutrition. Compounded with early marriage and seclusion after puberty, the situation of young girls is, perhaps, one of the most dismal in the world.

Table 2.1 Population, Education and Health in Afghanistan

1.	**Population**
	■ Population: 23.2 million in area 647,500 sq. km ■ Female adult literacy (15+): 15 per cent ■ Female adult literacy rate as a percentage of males: 36 per cent
2.	**Education**
	■ Primary school net enrolment ratio: 54% (Boys 67%, Girls 40%) ■ Primary school education completion rate: 23% (Boys 32%, Girls 13%) ■ Primary school attendance: 54% (Boys 67%, Girls 40%) ■ Ratio of girls to boys in primary education: 0.6 ■ Secondary school enrolment (gross): 35 per cent
3.	**Health**
	■ Access to safe water: 23% ■ Access to sanitation: 12% ■ Schools with access to improved water source: 25% ■ Schools with access to improved sanitation: 20% ■ Access to health services: 30% ■ Under-five mortality rate: 275 per 1000 live births ■ Maternal Mortality Rate: 1600 per 100,000 ■ Diarrhoea mortality proportion under 5: 30%

Source: Islamic Republic of Afghanistan, National Strategy for Health School Initiative, March 2007 (education data), National Strategic Plan for Education 2006 (all other data)

According to the projection data of the Ministry of Education, Afghanistan, approximately 83 per cent of all children attending school are at the primary level, 12 per cent are at the lower secondary level and a mere 4 per cent attend the secondary level. The gender parity ratio is 59.7 in primary, drops to 36 in lower secondary and goes further down to 31.9 in higher secondary (Ministry of Education, Afghanistan, 2006). Over 50.9 per cent of all primary school children in Afghanistan are in urban areas. The figure goes up to 86.9 in lower secondary, indicating a big rural–urban divide in the country. The participation of girls at the higher secondary level remains negligible. The UNICEF MICS survey report of 2001 reveals a grim picture with respect to immunization, vitamin A deficiency, diarrhoea, acute respiratory infections and so on. The burden of work, especially chores like fetching water, cleaning and childcare, invariably fall on the girls' shoulders. Given the political climate of the country, poor health and sanitation affects both boys and girls, but the impact on girls' education is more severe.

Compared with the rest of South Asia, the urban scenario, too, is challenging here.

ISSUES FACING CHILDREN IN AFGHANISTAN

- Infant, under-five, and maternal mortality rates in Afghanistan are among the world's highest. Twenty-five per cent of children die before reaching their fifth birthday. Fifty women die each day from pregnancy-related complications.
- More than half of all children are stunted.
- Because immunization coverage is still very low, preventable diseases kill thousands of children annually. Malaria (which afflicts approximately 2 million people per year), measles, and respiratory infections are the leading causes of childhood death.
- The great majority of Afghanistan's population lacks access to safe water or sanitation. Diarrhoeal diseases and tuberculosis are chronic threats to public health.
- Two million children of primary school age do not attend classes. Literacy rates are low.
- The gender gap in education is narrowing, but girls still lag far behind boys in school enrolment.
- Landmines and unexploded ordnance pose a serious risk to children's safety.

Source: UNICEF website, www.unicef.org/infobycountry/afghanistan_background.html, accessed on 15 March 2008.

Urban poor do not have access to basic services and social infrastructure. This severely affects their ability to earn enough. This, in turn, impacts their capacity to send their children to school and keep them there. Investments in providing water and sanitation, shelter and basic healthcare have been insufficient. New migrants and informal settlements are simply ignored. Given that economic insecurity and absence of livelihood opportunities pushes the poor in rural areas to migrate, the situation is grim. The plight of widows and women who are left to fend for their families has been documented already in the international media. A recent report on the status of health and education among the urban poor revealed that children are most susceptible to infections and illness. Invariably, it is the girls who end up tending to them. The report also found that it was rare to find a girl continue in school after puberty (Beall and Schutte, 2006). While there is no data available on employment opportunities available to women and girls, their vulnerability to sexual exploitation at work cannot be ruled out.

Afghanistan is the world's largest producer of opium, which is used to make heroin. According to 2005 UNODC estimates, there are about 50,000 heroin users in Afghanistan and about 15 per cent of men use needles to inject drugs (World Bank, 2007). Combined with illiteracy (only 47 per cent of men and 15 per cent of women are literate), the country faces a major challenge in the area of HIV awareness and prevention.

The educational and health conditions of the people – especially of women and girls – go hand in hand. The regions/ provinces with the worst health and nutrition indicators are also the areas where educational status is poor.

2.2 Bangladesh

Bangladesh has made significant progress in the last ten years on a number of key human development indicators – notably, girls' education, under-five mortality and infant mortality. But high levels of poverty and ecological disasters – frequent flooding and land erosion – persist. According to the B-HDR 2000, 'The total number of poor women is higher than that of the men. The traditional society of Bangladesh is permeated with patriarchal values and norms of female subordination, subservience, subjugation and segregation. These consequences result in discrimination of women at birth, leading to deprivation of and access to all opportunities and benefits in family and societal life, thus putting women in the most disadvantageous position' (Rashid, 2005). Various micro-studies indicate that the 'hardcore' poor are largely women (Rahman *et al.*, 2005).

Notwithstanding the grim poverty, government estimates indicate that close to 97 per cent of children (6–10 years) are enrolled in school and the Gender Parity Index (GPI) is 0.97. The B-HDR 2000 reveals that while the overall secondary school enrolment is only 43 per cent – 44 per cent for girls and 42 per cent for boys – it is believed that free education at the primary level has had a positive impact on girls' schooling. All poor students receive a stipend if they enrol and attend primary school. Girls get a stipend at the secondary level also. The Bangladesh Female Secondary Stipend Assistance Programme supports girls in the age group 11–14 and has shown positive results despite the bias against girls' education. The stipend covers tuition, books, uniforms and transportation, and its continuation is conditional on 75 per cent attendance and scoring at least 45 per cent in examinations. The stipends go straight into bank accounts and the programme is monitored closely (Mahmud, 2003, cited in UNGEI/ UNESCO, 2005). In spite of this, ensuring that the stipend benefits the poorest remains a concern. This is, indeed, a positive trend that loses sheen in the face of the fact that close to 30 per cent of 15–19 year olds are mothers (Herz and Sperling, 2004). The dropout rates at the primary level have fallen from 38 per cent in 1994 to 33 per cent in 2004. However, class repetition rate is high at 39 per cent (GoB and UN, 2005). Learning outcomes are reported to be low and quality of education remains a serious concern.

The prevalence of moderately underweight children (6 months to 6 years) has declined from 67 per cent in 1990 to 51 per cent in 2000. But the country still has a long way to go. Children 'continue to suffer from short-term acute paucity of food intake as well as longer-term under-nutrition' (GoB and

Table 2.2 Key HD Indicators of Bangladesh

- NER in primary education: 82.7 per cent
- Ratio of girls to boys (primary): 48:52
- Ratio of girls to boys (secondary): 52:48
- Ratio of girls to boys (tertiary): 36:64
- Transition from primary to secondary: 89.3 (all) and 95.7 (girls)
- Ratio of literate females to males (20–24 year olds): 55:71
- Under-five mortality rate (deaths per 1000 live births): 82
- Infant mortality rate (deaths per 1000 live births): 56
- Maternal Mortality Ratio (deaths per 100,000 live births): 320–400
- Legally stipulated age of marriage of girls: 18 years
- Proportion of maternal deaths caused by violence: 14 per cent

Source: Government of Bangladesh and UN Country Team: MDG Bangladesh Progress Report, February 2005

UN, 2005). Once again, regional differences are wide. Children, especially girls in rural areas, show higher incidence of malnutrition. The rural districts of Sylhet, Comilla, Faridpur, Tangail, Jamalpur, Noakhali and Chittagong are home to nearly 50 per cent of severely stunted children (GoB and UN, 2005).

CHILDHOOD NUTRITION AND HEALTH INTERVENTIONS IN BANGLADESH

The Bangladesh Integrated Nutrition Project (BINP) started in 1996, covered 40 rural thanas by 2000 (i.e. 8 million population or 8.6% of total rural thanas). It is a community-based nutrition project implemented by the Ministry of Health and Family Welfare (MoHFW) with financial assistance from the World Bank and technical assistance from UNICEF. It has three major components: national level nutrition activities, such as strengthening of existing nutrition activities, information, education and communication, programme development and institution building; community-based nutrition (CBNC); and inter-sectoral nutrition programme development. It addresses protein energy undernutrition, through supplementary feeding to growth-faltering and severely malnourished children; and in the long run, through behavioural changes related to the major problems of caring (for example, low levels of exclusive breastfeeding, delayed complementary feeding, and inadequate maternal nutrition during pregnancy) and through improved food security from intersectoral subprojects. Low birth weight (LBW) is addressed by providing pregnant women with the calories needed for proper weight gain during pregnancy. Micronutrient deficiency is combated through supplementing pregnant women with iron and folic acid, by motivating families to consume iodized salt, and by providing mothers with vitamin A capsules within two weeks of delivery.

Source: UNICEF website, http://www.unsystem.org/scn/archives/npp19/ch16.htm, accessed on 15 March 2008.

The rate of HIV prevalence is known to be less than one per cent. The problem of low participation in education is particularly rife among the socio-economically disadvantaged groups (tribal and hilly regions), people in remote areas and urban slums. For example, while the Net Enrolment Ratio (NER) among the richest is 89 per cent, it is only 58.8 among slum dwellers and 65.4 among the poorest quartile of the population (Tietjen, 2003). Between 10,000 and 20,000 women and children are reportedly trafficked each year (ADB, 2004). Safety of girls is therefore a big issue in the country, especially in more disadvantaged areas and communities, as parents do not feel secure sending young girls to school.

The most important learning from Bangladesh is that purposive policy actions can, indeed, make a difference in a social, cultural and economic environment that is loaded against women and girls. Making space for multiple providers – government, NGOs and direct economic incentives in the form of stipends – can stimulate demand for and provide access to education in different settings. Among the key interventions to promote the education and health of girls in Bangladesh are (Government of Bangladesh, 2003; UNICEF Bangladesh website, 2008):

- More than 2,220 community workers have made a remarkable impact in the impoverished Chittagong Hill Tracts. Each worker provides 25 to 30 families with preventive healthcare and early-learning programmes.
- Sanitation coverage has almost doubled since 2003. By the end of

ISSUES FACING CHILDREN IN BANGLADESH

- Maternal mortality remains high.
- Most rural women give birth at home, without medical assistance.
- Millions of children are malnourished.
- Roughly half of all children under age five are underweight. Primary school enrolment is relatively high, but many children – especially those in urban slums – are still denied their right to a basic education.
- Seven per cent of Bangladeshi children under age fourteen are in the labour force.
- Birth registration is extremely low, hindering enforcement of child protection measures.
- The rise in sea levels predicted due to global warming has the potential to displace millions.

Source: UNICEF website, www.unicef.org/infobycountry/bangladesh_bangladesh_background.html, accessed on 15 March 2008.

2006 the country had achieved 81 per cent coverage, with a target of full coverage by 2010.

- Throughout Bangladesh, 2,700 peer educators are reaching thousands of young people with vital information on HIV/AIDS prevention.
- 'Kishori Abhijan' is a project that promotes the rights of teenage girls and opposes practices such as child marriage. Vocational training has improved economic opportunities for more than 25,000 girls.
- Hundreds of learning centres in urban neighbourhoods and in the Chittagong Hill Tracts now offer preschool programmes.
- Bangladesh has achieved gender parity in primary education, with girls' enrolment rates at 86 per cent, compared with 82 per cent for boys.
- Enhancing access and quality of elementary education.
- Educational programmes for working children.
- Increasing the proportion of women teachers (percentage increased to 38 per cent in 2002).
- Innovations in non-formal education (NFE).
- Alternative primary school programme for 8–10 year old girls to enable them to complete the primary level.
- Proshika (NFE programme) for 8–11 year old girls.
- Bangladesh Rural Advancement Council (BRAC) programmes for 8–11 year olds and 11–14 year olds.
- Non-formal education for basic literacy.
- Stipend for poor children, especially girls.

What is noteworthy in Bangladesh is that progress on the educational front is mirrored in health-related indicators. While we do not have region-specific data to show a correlation, Table 2.2 shows that progress in both sectors has kept pace.

2.3 Bhutan

Bhutan is one of the remotest areas in South Asia. The country was isolated from the world till 1961 and remained a traditional, rural society. In a short period, it has made notable progress. The Bhutan HDR 2000 reports that over 90 per cent of the population has access to primary healthcare. Sixty-five per cent of people have safe drinking water. It is interesting that the government placed the Gross National Happiness of its people above the Gross National Product!

The 1998 Education for All Assessment shows the gross enrolment rate (GER) at the primary level at 72 per cent (boys 82 and girls 62) while the net enrolment rate (NER) may be as low as 53 per cent (boys 58, girls 47). Currently, only 69 per cent of those entering primary schools complete the seven years of primary education, 54 per cent complete lower secondary, and only 39 per cent reach the secondary level. In addition, 12–13 per cent of the students repeat their class every year. Bhutan has a high

proportion of nomadic tribes (12.7 per cent of the rural population) who move from their cultivated lands (base area) to greener pastures with herds of yak (UNICEF Bhutan, 2003). Mobility is a big issue for 68 per cent of the rural population, which impacts children's education.

Bhutan's efforts to improve the situation of children include improvement on both the educational as well as health fronts – as evident in Table 2.3. Increase in primary school enrolment has kept pace with decrease in child mortality rates, universalization of iodized salt and universal access to public healthcare.

Another unique aspect of Bhutan is that the government has not only focused on primary education, it has also made concerted efforts in the IXth Plan to promote vocational and technical education at higher levels and steered a comprehensive policy for sustainable livelihoods for youth in the renewable natural resource sector. This has provided a much-needed momentum to put children through primary and secondary education. The Bhutan Vision 2020 notes, 'the treatment of youth employment must move beyond the mere provision of vocational training opportunities and skill acquisition, even as these investments in education and training for young people continue to remain essential to furthering their employability ... proactive and integrated treatment of youth employment [is] essential to achieve the objectives of

Table 2.3 Key HD Indicators of Bhutan

- Life expectancy at birth is 66 for male and 66 for female
- Infant mortality is 40.1 per 1000 live births in 2005 (it was 203 in 1960)
- Under-five mortality is 61.6 and maternal mortality is 255 per 100,000 live births
- No polio reported and the country is polio-free
- On the verge of eliminating maternal and neo-natal tetanus
- Iodine deficiency was a serious problem – today more than 90 per cent of edible salt sold is iodized. In 1964, goitre prevalence was 64.5 percent among children. In 2003, Bhutan was declared IDD-free
- Primary healthcare is free for all and 78 per cent of women in villages live less than two hours' walk from an outreach clinic
- No gender differences evident in nutrition and healthcare of boys and girls
- Gross enrolment ratio for primary level (2006) is 102 per cent with little gender difference
- Net primary school enrolment ratio is 80 per cent for boys and 79 per cent for girls
- Gender gap is high at secondary level
- To date, 83 people have been identified as HIV positive among Bhutan's population of about 700,000[13]

Source: Bhutan HDR (2000), Bhutan National Human Report (2005) and UNICEF (2003)

Gross National Happiness and constructive human development.'

Gender-specific information is not readily available, especially regarding the impact of health on education and the overall status of women in society. The dominant perception is that there is no significant difference in attitudes towards boys and girls. However, the larger South Asian trend of boys staying behind to care for parents in their old age is prevalent also in Bhutan.[14] The barriers to continual participation of girls, particularly in rural and remote areas, are lack of safety in commuting to school because of the distances and the tough terrain. Also, they are required at home. Besides, there is the cost of sending children to school. As a result, parents are now demanding hostel facilities and residential schools. Isolated habitations bring with them the problem of access. The government has tried community schools and non-formal methods, but it has realized that these methods cannot effectively substitute for formal education.

2.4 India

India, the most populous country in the region, is a land of great diversity and sharp disparities. Since the 1990s, physical access to primary schools has improved considerably. As many as 152,304 new primary schools and 110,830 new lower secondary schools have been opened since 1990 (Select Educational Statistics, GoI, 2006). The 1990s saw a sharp increase in the rate of improvement in girls' education and women's literacy. The percentage of 'never enrolled' children has been steadily decreasing. The GER in the primary stage exceeds 100 per cent. Yet the disparity in the gender ratio persists, as do differences between different social groups, notably the Scheduled Caste (SC – a social group that continues to be at the bottom of the social and economic ladder) and Scheduled Tribe (ST – communities notified as indigenous tribes in the Constitution of India) communities. This gap is significant at the lower secondary level. An important exception to this trend is the Muslim girl child. Recent studies indicate that Muslim children, more specifically girls, still lag far behind when it comes to enrolment and retention in school.

The 55th and the 61st Rounds of NSS data reveal that there has been improvement in the current attendance rates in the age group 5–14. Notwithstanding a secular increase across all social groups, the proportion of rural women from SC and ST social groups attending any educational institution in 2004–05 is 678 per 1000 for ST and 737 per 1000 for SC. There is at least a 10 percentage point difference between boys and girls of the same social group and location. *Social group and location emerge as the two important markers – with the educational level of both SC and ST men and women in rural areas being much*

lower than other social groups in both rural and urban areas. While access-related indicators have certainly improved in the last 10 to 15 years, there has not been an appreciable decline in the gender gap in real terms. This is because parents choose to send their boys to fee-paying private schools and girls to free government schools. As a result, the decreasing gap between girls and boys in enrolment to government schools (as captured in DISE data) does not tell us very much about gender disparities per se.

Girls continue to drop out in large numbers. As many as 28.57 per cent of girls drop out before they complete primary school, 52.32 per cent drop out before they finish lower secondary school and 62.69 per cent quit before they complete the secondary level. The figures are even more dismal for SC and ST girls. Sixty-two per cent of SC girls and 71.4 per cent of ST girls do not complete the lower secondary cycle, and 75.5 per cent of SC girls and 81.2 per cent of ST girls do not reach class 10. Rural–urban differences are also significant. Girls far outnumber boys on the dropout scale. The intermeshing of gender relations, location (rural/urban, remote areas) poverty, social disadvantage/ discrimination and poor quality schooling loads the dice against girls.

An analysis of the trends between the 1991 and 2001 Census of India reveals 'while the Muslims in 1999–2000 were only a shade more illiterate than the Hindus in rural areas (48 per cent versus 44 per cent of the Hindus), in urban areas the gap is much wider – 30 per cent versus only 19 per cent among the Hindus ... enrolment rates of Muslim girls have steeply fallen relative to the all-India average, especially during and after the decade of the 1990s' (Shariff and Razzack, 2006). Muslim girls emerge, by far, as the most marginalized group in India. Of those enrolled, over 70 per cent of ST and 55 per cent of SC girls attend school regularly. In comparison, only 35 per cent of Muslim girls go to school. Over one in three poor Muslim girls never go to school (Social and Research Institute, 2005). While the Muslim Literacy Rate (MLR) in Assam is 48 per cent, the female literacy rate in the community is 40 per cent – 8 per cent lower than the MLR. Similarly, the MLR in West Bengal is 57 per cent whereas female literacy among Muslims is 49 per cent. This divide is even more pronounced in Bihar where the 2001 Census of India showed that the differential between the male and female literacy rates in the Muslim community is 11 per cent.

The issue of 'missing girls' hit the headlines when the 2001 census was released. The data in the census was a telling reflection of a society's deep-rooted preference for sons. It revealed that the sex ratio among children below the age of six was alarmingly low in some regions of the country. Sex-selective abortions and the declining sex ratio reveal one side of the phenomenon.

But as we dig deeper, we may be able to discern other manifestations. For example, the recent ASER 2007 survey facilitated by Pratham (a NGO in India) has revealed some interesting trends (Pratham India, 2005 and 2007). Over 60 per cent of children in private schools are boys. The boy–girl ratio in different states also tells us that parents are willing to invest more in the education of their sons. The lowest figures come from Rajasthan where the boys-to-girls ratio in private schools is 68:32. Kerala is at the other end of the spectrum with a ratio of 49:51. The data on out-of-school children confirms the trend. In Rajasthan, 65 per cent of the total out-of-school children are girls, 67 per cent of children in private school are boys and the sex ratio is rather lopsided. The information from Punjab is startling. The state has the lowest juvenile sex ratio (with only 793 girls for 1000 boys in the 0 to 6 age group). Many more boys study in private schools. This also tells us something about the kind of choices parents make.

The Infant Mortality Rate (IMR) has dropped considerably from 146 per 1000 births in the 1950s to less than half of that figure of 70 in 1999. This drop, even by world standards, is quite impressive (World Bank, 2001a). However, the pace of decline in infant mortality in the 1990s has been sluggish compared with the previous decades. This is a cause for concern. That apart, the rural–urban gap in infant and child mortality has marginally increased, reflecting stagnation and decline in rural health services. Barring the pulse polio campaign, the deceleration in basic health interventions and immunization seems to be partially responsible for the slow decline in infant and child mortality. Data compiled by the Sample Registration System (SRS) suggests that neonatal mortality (mortality in the first 28 days of a baby's life) is disturbingly high in India at about 53 per 1000 live births. The pace of decline in this phase is slower compared with the turndown in

Table 2.4 Gender Inequalities: Sex Ratio, Schooling and Out-of-School Children in India

States ranked on juvenile sex ratio	Girls to 1000 boys in 0–6 age group Census 2001 (GoI)	Boys:Girls in private schools ASER 2005 (Pratham)
Punjab	793	58:42
Haryana	820	64:36
Gujarat	878	61:39
Himachal Pradesh	897	58:42
Uttarakhand	906	66:34
Rajasthan	909	67:33
Uttar Pradesh	916	62:38
Maharashtra	917	52:48
INDIA	927	60:40

Source: 2001 Census of India; Pratham India (2005)

the post-neonatal phase. This slow pace is linked to maternal factors, such as early marriage and childbirth, and low utilization of antenatal care and obstetric services.

Malnutrition is another big issue in the country. The recent NFHS-3 reveals, 'The most striking has been the increase in wasting ... among children. NFHS-3 found 19 per cent of children wasted, up from 16 per cent seven years earlier. At the same time, there has been virtually no change in the percentage of children who are under weight (47 per cent in NFHS-2 and 46 per cent in NFHS-3). NFHS-3 also found a remarkably high prevalence of anaemia – 79 per cent – in children between 6–35 months. The prevalence of anaemia is even worse than it was in NFHS-2 (74 per cent). Anaemia in India is primarily linked to poor nutrition.'[15]

Health, education and nutrition go hand in hand – it is important to note that

ALARMING FINDINGS ON CHILD HEALTH AND NUTRITION IN INDIA
WHAT NFHS 3, NSSO (58, 60 AND 61 ROUND[16]) REVEAL

- 28.3 per cent of rural people live below the poverty line (below Rs 356 per capita per month) in India – with wide interstate variations – 46.68 in Orissa and Jharkhand and 4.6 in J&K and 5.4 in Goa (NSS 61).
- Undernutrition is serious in rural areas, in lower wealth quartiles, among scheduled tribes and scheduled castes and among families with no educated adult (NFHS-3).
- The average per capita per day intake of cereals other than rice and wheat declined from 130 (40) grams in 1983 to 50 (50) grams in 1999/2000 for rural (urban) India (NSS 58; Viswanathan and Meenakshi, 2006).
- Percentage of undernourished is far higher than the income poverty rates (NSS 58 triangulated with NFHS-3).
- While infant mortality rates have steadily declined, 1 in 18 children still die within the first year of life and 1 in 13 die before reaching age 5 (NFHS-3).
- Less than half (44%) of children in 12–23 months age group are fully vaccinated against six major childhood illnesses (NFHS-3).
- Almost half of children under age five are stunted, 20 per cent are wasted and 43 per cent are underweight (NFHS-3).
- Only about half the children in the age group of 6–9 months receive semisolid food. As a result of the faulty infant and young child feeding practices, there is a steep increase in the prevalence of undernutrition from 15.4 per cent at less than 6 months to 52.6 per cent in the 12–23 months age group (NFHS-3).
- Only 33 per cent of age-eligible children received any service from the ICDS centre, 26 per cent received supplementary food, 20 per cent received immunization and the growth was monitored of only 18 per cent of children (NFHS-3).

areas characterized by low educational participation are also the ones where health, immunization and nutritional status is poor. Gender differences are also more pronounced in areas/ communities with poor health, education and nutrition indicators. The intermeshing of high rates of malnutrition, regular bouts of preventable diseases – like malaria, diarrhoea and respiratory tract infections – severe anaemia and poor health of adolescent girls, and early marriage among the most deprived sections contributes to poor

RAJMATA JIJAU MOTHER–CHILD HEALTH AND NUTRITION MISSION, MAHARASHTRA, INDIA

The Rajmata Jijau Mother–Child Health and Nutrition Mission was constituted by Government Resolution dated 11th March 2005 issued by the Department of Women and Child Development, Government of Maharashtra with the primary objective of reducing Grade III and Grade IV malnutrition in children in the 0–6 age group in the State of Maharashtra. The project also sought to ensure neo-natal care to pregnant women, new-born care and special focus on health; nutrition and complete immunization of children in the 0–3 age group and assist the Public Health Department in provision of training for implementation of home-based new-born care programmes on a pilot basis in selected primary health centres (PHCs). The project focused on three issues: survey, weighing, gradation.

- Stress on full coverage (100% as level for survey efficiency and 95% as acceptable lower limit for weighing efficiency)
- Special focus on Grade III/IV reduction
- Regular medical examination
- Fact finding, not fault finding
- Local initiative in nutrition/health measures
- Involvement of community, especially PRIs, mothers' groups
- Antenatal care
- Feeding practices
- Complete immunization
- De-worming
- Micronutrient supplementation
- Nutrition/health education

While no evaluation reports are available of this programme (the programme is less than 3 years old), it is believed that such a community-based programme has been able to make an impact.

Source: Government of Maharashtra and website http://hetv.org/nutritionmission/.

educational as well as health outcomes (Ramachandran, V., 2004). Recent evidence is that the prevalence of corporal punishment and other forms of abuse of children – especially from deprived social groups and communities – pushes many of them out of school.

A worrying phenomenon is the resurgence of polio in India. The alarm bells rang in early 2003. The *British Medical Journal* reported, 'From 1 January to 10 October 2006 the number of confirmed polio cases worldwide stood at 1403 (the number for the same period in 2005 was 1349), of which 888 were in Nigeria (up from 489 in the same period last year), 360 in India (37 last year), 24 in Pakistan (18 last year), and 28 in Afghanistan (four last year)' (Zaracostas, 2006). Among the reasons debated is the failure of the vaccination programme.

India is now among the high-risk countries with respect to HIV/AIDS and home to over 60 per cent of Asia's estimated HIV infections. An estimated 5.7 million people in India are living with HIV/AIDS, with a prevalence rate of 0.9 per cent among adults aged 15–49 years (UNAIDS, 2006). *However, recent revised estimates suggest that the number of people estimated to be living with HIV/AIDS in India is about 2.47 million, or half of previous estimates, according to United Nations-backed government estimates released on 6 July 2007* (GoI press release quoted in national media on 7 July 2007).[17] The prevalence is highly varied with six of the 28 Indian states reporting two-thirds of the cases. These are also the more developed areas of the country. Infection levels are over 1 per cent in Andhra Pradesh, Karnataka and Maharashtra and the situation in Tamil Nadu is also known to be quite worrisome. The biggest concern in India is that young women and adolescent girls are getting the infection from their husbands. Unfortunately, the existing gender relations do not allow them to ask about the HIV status of their future husbands. Nor are they able to negotiate safe sex within marriage.[18]

2.5 Maldives

Maldives is an Islamic island country in South Asia and is ahead of the other countries in the region in terms of girls' education and health. With a small population of 270,101 as per 2000 figures, it is one of the few countries where health is a basic right of every citizen. Maternal mortality has decreased from 400 per 100,000 live births in the 1990s to 75 in 2000. Similarly, immunization coverage is almost 98 per cent for all vaccine-preventable diseases. Seventy-six per cent of the population has access to safe drinking water and 85 per cent to excreta disposal facilities. As a result of the improved healthcare system, life expectancy at birth is 70.7 for men and 72.2 for women. The economy is based on fisheries and tourism. It is an educationally advanced area where the literacy rate of the population between 10–45 years of age was 98.94 per cent in 1999.

Table 2.5 Numbers Tell a Good Story – Maldives at a Glance ...

- Life expectancy at birth (in years) HDI 2000–05: 66.3
- Life expectancy at birth – female (in years), 2004: 66.6
- Infant mortality rate (per 1000 live births): 35
- Under-five mortality rate (per 1000 live births), 2004: 46
- Maternal mortality ratio reported (per 100,000 live births), 1990–2004: 140
- Maternal mortality ratio adjusted (per 100,000 live births), 2000: 75
- Net primary enrolment ratio (per cent), 2004: 90
- Percentage of HIV prevalence (15–49 age group), 2005: <0.2
- Adult literacy rate – female (percentage 15 and older): 96.4
- Combined gross enrolment ratio for primary, secondary and tertiary: female (%), 2004: 69
- Combined gross enrolment ratio for primary, secondary and tertiary: male (%), 2004: 68

Source: MPND and UNDP (2004)

The above indicators hide some concerns about the situation of women and girls in the island. Nearly 50 per cent of the households are headed by females as men migrate for work. The mean age of marriage is reportedly as low as 16.8 years. Use of contraceptives is low and the average number of children born to a woman is high at seven (ADB Philippines, 2001).

Malnutrition due of lack of protein intake remains an area of concern. Even though the situation in the Maldives is better than in the other South Asian countries (with the exception of Sri Lanka), the MPND and UNDP Vulnerability and Poverty Assessment study carried out in 1998 revealed sharp gender differences among children who were stunted (height for age – indicating inadequate nutrition over a long period) and wasted (weight for height - may also indicate short-term illness/deprivation/hunger). Fourteen per cent of boys against 16 per cent of girls were stunted and 22 per cent of boys against 42 per cent of girls were wasted. However, the most recent Vulnerability and Poverty Assessment (2004) revealed that the levels of malnutrition had come down and gender differences regarding stunting had virtually disappeared (MPND and UNDP, 2004). Not much information is available on the prevalence of violence and HIV/AIDS. As of mid-2004, 14 people tested positive for HIV, and 10 people died of AIDS. The number of people in the Maldives living with HIV or AIDS is less than 200 (UNAIDS, 2006).

2.6 Nepal

Nepal is a country of rich geographical, ethnic and linguistic diversity. Until recently, it was a Hindu Kingdom and is now in the process of becoming a republic. It has seen ten years of armed conflict. Gender differences in Nepal are great, with an NER of 73 for girls (total NER is 83 per cent) as per 2003 figures (Central Bureau of Statistics, Nepal,

2004). According to the 2001 household survey data, girls' participation in primary schooling continues to be 10 percentage points lower than that of boys. Rural–urban disparities are quite sharp and there is also a big difference between the richest quartile and the poorest quartile. According to Friedrich Huebler, 'in rural areas, 72.0 per cent of children of primary school age are in school, compared with 89.8 per cent in urban areas. The biggest disparities are linked to household wealth. In the richest 20 per cent of all households in Nepal, the primary NAR is 94.3 per cent. As household wealth declines, the primary NAR also falls and among children from the poorest 20 per cent of all households, the primary NAR is only 59.6 per cent' (Huebler, 2007).

There are vast regional differences too. The NER for girls is 88.8 per cent in Kathmandu, 30 per cent in Achham and only 22.6 per cent in the Terai districts (Singh, 2004). Even though the average age of marriage is now 19.5 years, this parameter, too, has many regional variations (HDR, 2004). Over 40 per cent of girls get married before they reach their 15th birthday and marriages of 10–12 year-old girls are not uncommon. With some exceptions, marriage means the end of schooling. The female adult literacy rate stands at a low of 35 per cent (2004).

The IMR was 56 per 1000 live births, under-five mortality was 74 and neonatal mortality was 40 in 2005

HEALTH AND NUTRITION ISSUES FACING CHILDREN IN NEPAL

- More than 50,000 children die in Nepal each year, with malnutrition as the underlying cause for more than 60 per cent of these deaths. Girls are at a greater disadvantage than boys.
- Half of the children in Nepal are underweight and three-fourths of the pregnant women are anaemic.
- The detection of a few cases of wild poliovirus in 2005, following five years without any case, indicates the challenge for cross-border transmission along the border with India. Fifteen per cent of Nepal's wells are contaminated by arsenic.
- Despite Nepal's high overall coverage of accessibility to drinking water, access to improved water for deprived, disadvantaged communities and conflict-affected rural and fringe urban areas remains low. As a result women and girls spend a great deal of time fetching water.
- Two-thirds of Nepali people are still without access to toilets. This affects girls and women far more.

Source: UNICEF website, www.unicef.org/infobycountry/nepal_nepal_background.html, accessed on 15 March 2008.

(SOWC, UNICEF, 2007b). The life expectancy of women improved from 53.5 years in 1991 to 61.5 in 2001 – slightly higher than the male life expectancy of 60.5 years. Unlike India, the sex ratio is favourable at 99.8:100. One of the most disturbing aspects of women's health, however, is a very high maternal mortality rate (539 per 100,000 live births in 2001). The Human Development Report of 2004 points out that one out of every 185 pregnant women dies and only 53.4 per cent of women receive any antenatal care.

The first case of AIDS in Nepal was reported in 1988. By 2005, 950 cases of AIDS and over 5800 cases of HIV infection were officially reported. Three times as many men as women are reported to be infected. A recent UNAIDS and World Bank report points out that, 'given the limitations of Nepal's public health surveillance system, the actual number of infections is expected to be much higher.' UNAIDS estimates that 75,000 people were living with HIV at the end of 2005 (cited in World Bank, 2006).

A recent Technical Review of School Education in Nepal (Acharya, 2006) reveals that Nepal has made appreciable progress in the last ten years. Early childhood development centres for children below six years (ECD) are spreading, albeit slowly, and the participation of Janajatis and Dalits, and girls, has improved. Schools have functioned through the political turmoil and the community has started participating more actively in the school management. Women teachers and local people have encouraged enrolment of remote and, hitherto, non-participative communities. However, the retention rate remains low. As discussed in the preceding sections higher participation of girls in education – especially beyond primary level – yields positive health outcomes.

Recent studies reveal that girls' education and health remain areas of concern. At Grade 1, the retention rate for girls is 89 per cent for 2005/06 – with just a percentage point difference between girls and boys. This is 2 percentage points more than the previous year. One-third of the sampled schools in the TRSE review were not able to maintain this average retention rate. In eight per cent of the sampled schools, the retention rate was less than 50 per cent, and retaining Dalit students was reported to be a challenge.

The survey also reveals that the retention rate was not related to the growth rate in enrolment at Grade 1. In fact, retention was high where growth was low and vice versa, indicating that many high enrolment schools may have experienced an artificial influx of students. Many students dropped out when they did not receive their scholarship money in time. This problem is reportedly quite grave in the Terai region. The good news is that once girls

reach lower secondary, they seem to stay on until the secondary level – most of the dropouts occur during transition from primary to lower secondary. When more girls move on from primary to secondary there would be positive health outcomes.

Given the recent political changes in the country, it may be some time before the new government comes to grips with the educational and health situation in the country. While a number of policies have been introduced to promote girls' education and child health, it may be a bit premature to say whether these policies and programmes will be continued in the near future.

2.7 Pakistan

Pakistan has been through difficult times in the last decade. War in the region and internal conflict has resulted in a challenging social and political environment, especially for girls and women in the country. Maternal mortality ratio is estimated to be about 500 per 100,000 live births and one in ten children does not survive their fifth birthday with the majority of deaths due to diarrhoea, pneumonia or vaccine-preventable diseases. Thirty per cent of children are chronically malnourished and lack safe water and household sanitation, especially in rural areas. Even more worrisome is that an estimated 3.6 million children under the age of 14 work, mostly in exploitative and hazardous labour – most girls work within their homes/communities and therefore they are not visible. The silver lining is that polio cases have dropped from 1,100 cases in 1997 to 40 in 2006 by vaccinating 95 per cent of targeted children (32 million) at least four times a year. More than 28 million children under five receive vitamin A supplement twice a year. By March 2008, Pakistan had completed a measles campaign to immunize more than 63 million children.[19]

The educational scenario in Pakistan is comparable to other South Asian countries, especially India and Nepal. Compared with 76 per cent of boys, about 56 per cent (net) of girls are enrolled in primary school. Just over a third of Pakistani women are literate. The overall literacy rate in Pakistan increased over 25.9 per cent in 1980 to 45 per cent in 2000. The highest literacy rate is among urban males in Punjab and the lowest amongst rural females in Baluchistan. The highest increase in the female literacy rates in rural areas from 6.6 per cent in 1990/91 to 16 per cent in 2001/02 is in the North-West Frontier Province (NWFP) and from 2.2 per cent to 11 per cent in Baluchistan. In contrast, female literacy rates in rural Sindh and Punjab declined in the same period. In 2001, girls constituted 41 per cent of the total enrolment in primary schools, which is only a slight increase from 39 per cent in 1991. In the provinces as well, the gender gap has not reduced significantly. If anything, it has increased between 1996 and 2001 in

places such as rural and urban Baluchistan, urban Sindh and the NWFP. This increase in the gap may be real. On the other hand, it may simply reflect the increased number of girls going to NGO-supported community schools for girls that are not represented in the statistics. A comparison of net enrolment at primary, secondary and senior secondary (Class 10) levels shows that less than half the rural girls who are enrolled in primary school may enter the middle school and about half of those in the middle school may enter secondary school. On the other hand, more than half the boys at each level may reach the next level. The Pakistan Household Survey (2001/02) shows that parental refusal is the most common reason given by girls (10 to 18 years) who have never attended school in all provinces in both urban and rural areas (Farah and Shera, 2004).

According to the Education for All *Global Monitoring Report* (2003/04), 7.85 million children in the 6 to 11 age group were out of school, while UNICEF estimates that the number could be as high as 13 million. The educational policies of 1998–2010 emphasize UEE and admit that enhancing girls' access and retention is the biggest challenge to this. Given the enormity of the task, educational policies in the post-Jomtien[20] period focused both on formal and non-formal education. The Asian Development Bank supported the Girls' Primary Education Development Programme (1993–96 and 1996–2004). The World Bank, primarily, and some other donor agencies supported the Primary Education Development Programme (1990–98).

Community partnership for education was first tried out in Baluchistan where only 19.9 per cent of girls were enrolled. As Farah and Shera point out, 'This situation could not be explained only in terms of religious and cultural restrictions in a tribal society. In fact, a very obvious reason was also the absence of primary schools for girls. In 1990, of the total number of primary schools in Baluchistan, only 8.3 per cent were for girls, 14.1 per cent of all middle schools and 22.1 per cent of all high schools were for girls ... In this situation, a community-support programme to establish and manage rural primary schools was developed. Village communities were mobilized through a step-by-step process and supported by NGOs partnering with the government. Once the community was sufficiently motivated, it committed to enrol enough students and identified a local woman to serve as a teacher. The government provided supplies and the salary of the teacher. The village education committee was made responsible to manage the school for three years and ensure continued student enrolment and attendance and monitor the teacher's attendance. The VEC members were supported by the NGOs and government staff that also offered training for them. If they could successfully operate the school for three

years, the government would build a permanent building, formalize the teacher as a government employee and regularize the school. Similar strategies of involving the community were used in other provinces. In Sindh, the Sindh Education Foundation – a semi-autonomous institution – disbursed funds to community-based organizations (CBOs) to open schools with community participation. Other larger I/NGOs, such as the Aga Khan Education Services, also supported such community-based organizations' (Farah and Shera, 2004).

Pakistan experimented with a fellowship programme where the government agreed to pay the enrolment fee and provide a subsidy for 100 girls if the community opened a school. However, this programme did not take off as expected in rural areas, although it was fairly successful in urban areas. This is evident from the fact that in 1997 the number of girls in primary school increased by 24.1 per cent (from 503 in 1990 to 1719 in 1997) and the enrolment in all girls' primary schools increased by 86.2 per cent. The dropout rate also decreased so that almost 30 per cent of girls were completing primary school in 1997 as compared with only 7 per cent in 1990. Enrolment in middle and high schools also went up (Anzar, 1999). The fellowship model was replicated in urban and rural Sindh with considerable success (Farah and Shera, 2004).

The HIV/AIDS situation in Pakistan is not yet alarming. It is most prevalent among men between 20 and 44 years – 2903 cases as per 2006 figures. Pakistan has relatively high prevalence of injecting drug users (IDU), 64 per cent of whom report use of non-sterile needles. This is a worrying trend, a cycle in fact. It may lead to higher rates of infection among

Table 2.6 Net Enrolment Ratio at Different Levels of Schooling, Pakistan

	Primary Enrolment Ratio (%)								
Area	1990			1995/96			2001/02		
	M	F	Both	M	F	Both	M	F	Both
Urban	61	57	59	56	55	55	65	63	64
Rural	50	31	41	47	31	39	54	38	47
Total	53	39	46	49	38	44	57	45	51

	Middle Enrolment Ratio (%)						Matric. Enrolment Ratio (%)					
Area	1995/96			2001/02			1995/96			2001/02		
	M	F	Both	M	F	Both	M	F	Both	M	F	Both
Urban	40	37	38	38	43	40	24	24	24	27	28	27
Rural	29	10	20	27	15	21	17	6	11	17	8	13
Total	33	19	26	30	23	27	19	12	16	20	14	17

drug users who may pass it on to the young women they marry. IDU cases all over the country have started recording alarmingly high rates of HIV. According to the latest figures released by the National AIDS Control Programme of Pakistan, HIV/AIDS prevalence among IDUs jumped from 0.4 per cent in December 2003 to 7.6 per cent in 2004. It is estimated that once the epidemic reaches a critical juncture, it will spread to the general population. It is imperative, then, for girls and women to know that they might be at risk of contracting the infection through marriage (World Bank, 2007).

2.8 Sri Lanka

Sri Lanka is known for its good human development indicators in South Asia. For almost six decades the country had free and universal education up to senior secondary. Literacy is high and the gender gap virtually absent. But the last two decades have seen a great deal of conflict and violence in Sri Lanka, not to mention the recent Tsunami that devastated larger coastal areas. It is reported that unemployment among women is nearly double that of men even though the status of women here is much better than in most South Asian countries – women's status in Sri Lanka matches the status of women in Kerala in India. Sri Lanka has a good public health system and female life expectancy is 74 years.

Most of the data that is available is from the non-conflict areas – IMR is 17 per 1000, under-five child mortality is 19 per 1000 and the maternal mortality rate is 23 per 100,000 live births. It is noteworthy that the female infant mortality rate is lower than the male rate.

The Census 2001 data reveals that 95 per cent of children attend school and that the retention rate in primary classes is 96.9 per cent for boys and 98.3 per cent for girls. At secondary level (Class 9), the retention rate is 79.1 per cent for boys and 86.3 per cent for girls. Sri Lanka has achieved all the MDG goals in its non-conflict areas. Even so, gender stereotyping in schoolbooks is cited as one of the important gender issues in the country. Girls still opt for gender-specific careers. Violence against women is quite common but there is no gender-disaggregated data on violence.

Among the most pressing problems of the island is the armed conflict in several of its areas. Women in the conflict zone share a major burden – that of family survival. Conflict has impacted both boys and girls in these zones. Given the good HDR status of the country as a whole, there is dearth of published material available on the situation of health and education of girls among the poorest sections of society and in the conflict areas.

As per a recent UNAIDS estimate, Sri Lanka has a relatively small number of HIV positive people – about 5000 adults. Since 1986, only 712 cases

have been officially reported. Under-reporting is a result of the limited availability of counselling and testing, the fear associated with seeking such services and the stigma/discrimination associated with the infection. More women than men have *tested* positive in Sri Lanka. This is because a large number of women travel to work in West Asia, for which HIV testing is mandatory. The current ratio of HIV positive men to women is reportedly 1.4 to 1. The reality, however, is that there may be far more men infected then women, as in most countries going through the early phase of the epidemic.

3

CONCLUSIONS AND RECOMMENDATIONS

As is evident in the preceding sections of this paper, the countries of the region have a lot in common, though there are some exceptions – notably Maldives, Sri Lanka and, to a certain extent, Bhutan. The status of women is fairly low. Educational levels are far from encouraging. Girls from poor families endure poor nutrition and bad health, are susceptible to violence, and suffer an excessive burden of work and minimal education. Given the commonalities, the strategies that these countries have chosen to promote the education and health of girls are fairly similar. Equally, the brief profiles of the eight countries in the region also reveal that this is a region of great diversity and formidable challenges. The silver lining is that the decade of the 1990s and the first six years of the new millennium have infused a sense of optimism. Yes, the situation of girls and women's health and their education is worrisome. But then, there is also a great deal of optimism.

3.1 Absence of Integrated Approach to Health and Education

At the outset, it is important to note that none of the eight countries have an integrated approach to the issue of health and education of children – both boys and girls. Given the gender relations in the region, there is recognition that a girl child begins life with a huge disadvantage that persists throughout her childhood, adolescence and adulthood. If she belongs to a rural or remote area and is from a disadvantaged community then these only intensify the disadvantages in accessing healthcare, nutrition and education. Yet, if we are to carefully scrutinize existing policies, we see that all the countries have sector-specific

policies and programmes to encourage girls' education. But the lack of a holistic/coordinated approach to health and education is also evident. While there is a global recognition of the potential impact of the HIV/AIDS epidemic, the countries in the region are yet to realize the role education can play in combating it (see Box 8: Country Strategies to Combat HIV/AIDS).

The region has seen a range of strategies to improve the overall health situation of children, particularly girls (see Table 3.1). The important learning from a rapid perusal of these strategies adopted across the region is that there is considerable knowledge as well as experience on what works in a specific situation. The worrying part is that their effectiveness depends on the ability to sustain it over a long period of time and to target the most deprived. Table 3.1 needs to be read in conjunction with the diagram **Ways in Which Health Affects Education of Girls** attached at the end of this paper.

Table 3.1 Strategies to Improve the Health Status of Girls

Health issues	Strategies that have worked in the region
Under-nutrition (protein energy and malnutrition)*	- Timing intervention to prevent early malnutrition – promote breastfeeding and supplementary feeding after six months - Nutritious meal at pre–school and in school (mid–day meal) - Adequate psychosocial stimulation/encouragement can make a difference in childcare centres and school - Education of mothers and prevention of maternal malnutrition
Iron deficiency and anaemia	- Nutrition education of parents followed by proper nutrition at home – supplements provided to families living in poverty - School feeding programme - Iron / folic acid tablets for children above the age of 10, especially girls - Focused programmes for adolescent girls' health, education and life skills (including nutrition education)
Post-puberty practices	- Ensure girls' toilets in all schools with adequate water to promote good menstrual hygiene - Education of girls on post–puberty changes, need for hygiene and iron depletion - Provision of subsidized sanitary napkins and education of parents on the need for proper menstrual hygiene and importance of preventing reproductive tract infections
Iodine deficiency	- Iodized salt made universal - Iodine supplements (study shows that it can reduce cretinism and improves IQ between 8–15 years)[21]
Worm infections	- De–worming programmes in school alongside supplementary feeding - Education about hygiene / clean water and better sanitation

Infectious diseases, tuberculosis, malaria, meningitis, scabies, gastrointestinal infections / diarrhoeal diseases	- Vaccination/immunization - Management of malaria - Educating children about importance of completing prescribed medicine regime (especially in tuberculosis) - Promoting of proper hygiene - School sanitation programmes – to educate children and also provide safe environment
HIV/AIDS impact on the school	- Education to gear itself to potential shortages (by preparing more teachers) - Deal with stigma by educating the teachers and also making school attractive and relevant to children, especially girls - Provide opportunity to interact more regularly/meaningfully with parents and community - Provide opportunity to address inclusion and education – all forms of discrimination: caste, tribe, gender and HIV/AIDS - Empowering girls and their families with adequate knowledge about HIV/AIDS
HIV/AIDS infection in children / risk of infection	- Surveillance – through random testing of pregnant women to estimate prevalence in the general population - ART and health/hygiene education of children - Making drugs accessible to infected children - Educating children about drug use and danger of contracting HIV/AIDS; drug awareness programmes
Violence and child abuse**	- Zero tolerance – no violence against children is justifiable and all violence against children is preventable - Recognize human rights obligations and Child Rights Convention (CRC) obligations - Create platforms/mechanisms to hear the voices of children – especially girls; child–friendly reporting systems - Prioritize prevention – proactive role of the government and civil society groups - Break the silence – more research and authentic information on the extent and types of violence – acknowledging the problem is the first step - Recognize that prevention requires coordination of different arms of the government – schools, health system, police, media and the courts
Corporal punishment, bullying and gender-based violence in schools***	- Clear national and regional/provincial policies against corporal punishment in schools - Child–friendly reporting systems - Posters and other educational material to inform children about their rights in school - Educate children about good and bad touch, their rights and where they can seek help

** Filmer (2003); Jukes (2006)*

*** UNICEF (2007)*

**** UNICEF (2007), Chapter 4*

Many initiatives have been taken in the education sector by countries in the region. However, they remain a kind of patchwork of some girl-specific projects and a few general strategies to enhance access, retention and completion. As a result many of these promising initiatives pale in the face of the magnitude of the problem. *A systemic, mainstream effort is essential to integrate gender concerns into the very fabric of the education system*. Such an approach could be geared to meet the educational needs of girls in different settings and situations.

A unique programme in the region is Mahila Samakhya – an effort of the Government of India to address the constraints that prevent women and girls from accessing education. Situated in the Ministry of Human Resource Development, Department of Elementary Education, this programme has tried to address the root cause of women's powerlessness and tries to encourage the education and empowerment of women and girls through village-level collectives/groups. One of the main outcomes of this programme has been enhanced participation of girls in schooling. In particular, this programme has enabled out-of-school girls to access education. The genesis of MS can be traced to the National Policy on Education, 1986, a landmark in the field of policy on women's education in India. The section on Education for Women's Equality (Ch XII, pp.105–107, GoI, 1986) focuses on empowerment of women as the critical precondition for their participation in the education process. For the first time, official policy recognized the persistent gender imbalances in education and the continued marginalization of women and girls. It privileged the radical role of education in redressing such imbalances and in empowering women. It recognized the need to move away from mere provision or improvement of educational infrastructure alone.

Given the complex and deep-rooted barriers to women's access to education, it was argued that it is only when women's agency is developed to address these barriers and they are empowered will the ground be set for their participation in the education process. This programme now works to ensure girls' access to schooling and, in particular, enables out-of-school girls to acquire formal education.

The government and the NGO community of Pakistan have similarly made several efforts to encourage girls' education. For example, the community schools and outreach programmes through NGOs have recorded some success. Similarly, incentives and direct 'in kind' assistance is also said to have enhanced girls' participation in education. Some of the important initiatives taken in Pakistan are as follows (Khalid and Mukhtar, 2002):

- Free 5 kg vegetable oil for girls who attend more than 20 days of school every month in Baluchistan and the NWFP

- Initiatives in Sindh province: School Nutrition Programme (SNP), free distribution of textbooks, rescheduling the school calendar, fellowships and community schools (run by village education committees or VECs), scholarships for working children
- Initiatives in the NWFP: Stipend for women teachers to improve their qualifications, scholarships for rural girls and free textbooks
- The Punjab Middle School Project and the Punjab Education Sector reforms introduced in 2003 targeted rural areas. Some of the strategies adopted in these programmes included involving community in the establishment and management of schools, encouraging public–private partnerships, improving school facilities, offering resources and incentives to parents and students, recruiting local female teachers, improving quality by developing instructional materials and training teachers, and recruiting local female teachers
- Private sector caters to 30 per cent of the students at the primary level and NGOs are encouraged to provide education for girls. They run close to 30,000 non-formal education centres for girls
- School Management Committees and Parent–Teacher Associations promoted
- Age limit exempted for women teachers.

Bangladesh launched the National Campaign for Social Mobilization for Basic Education in 1992 as part of which fees for rural girls were abolished, free uniforms were made available (later discontinued) and a stipend programme was also initiated. The female secondary stipend programme was introduced in 1993 (see Box 7). While the impact in terms of enrolment, retention and participation is encouraging, the government and their donor partners highlight that quality of education and learning continues to be a huge concern.

Another programme that has made a big difference to girls' education – especially in educationally backward areas and in severely disadvantaged communities – is the Kasturba Gandhi Balika Vidyalaya in 2004 (residential lower secondary education programme for girls in educationally-backward blocks of the country). This programme was designed in 2003 to reach out to out-of-school girls aged 11 and above. A recent national evaluation of the programme revealed that a large proportion of girls studying in the KGBVs are from disadvantaged social groups. Most of them had dropped out at various stages of primary education or did not have ready access to upper primary schools. It was found that some of the KGBVs are also catering to younger girls – to the ones who have dropped out at the primary level as well as to those who had never enrolled.

Feedback from the 12 states visited in 2007 revealed that the participation of girls from socially disadvantaged social

BOX 7: BANGLADESH STIPEND PROGRAMMES

The Primary Education Stipend Project (PESP) was initiated in January 2003 with the aim of increasing the educational participation – enrolment, attendance, persistence and performance – of primary school-aged children from poor families throughout Bangladesh by providing cash payments to targeted households.

The Bangladesh Female Secondary School Assistance Programme (financed by the IDA to cover 119 out of 480 upazilas or sub-districts) also started in 1993. The key components of the programme are: provisions of stipends and tuition fees for girls, improving quality through teacher training, provision of performance incentives to schools and students, provision of water and sanitation facilities, and strengthening the management capacity of the Ministry of Education both at central and field levels.

The impact of the secondary school assistance programme has been substantial for girls. There were 1.1 million girls in secondary schools in 1991. The number went up to 3.9 million in 2005. Female enrolment as a percentage of total enrolment increased from 33 per cent in 1991 to 48 per cent in 1997 and, further, to 56 per cent in 2005.

Simplified and streamlined distribution, coupled with water and sanitation facilities in schools, have made a big difference to girls' education and to their overall health and well-being.

Source: Tietjen (2003), Mahmud (2003), World Bank (2006).[22]

groups was good – 26.36 per cent of the enrolled students in the 12 states were SC, 31.43 per cent ST, 26.45 per cent OBC, 8.75 per cent BPL and 4.31 per cent from the Muslim community. This evaluation has concluded that the scheme is reaching out to girls from the most deprived sections in rural areas. That said, greater effort is required to reach out to girls from minority communities and other extremely disadvantaged social groups. Even in a short period of time, in every state, the KGBV has become an important component in the elementary education landscape of the educationally backward blocks of India (GoI, 2007).

All the eight countries have a maternal and child health programme in place. In some of them, they are known as Reproductive and Child Health programmes. These programmes focus on maternal nutrition, antenatal care during pregnancy and child health, aimed at adolescent girls and women in the reproductive age group. UNICEF estimates that out of the 38 million (in 2006), more than one quarter are young people aged between 15 and 24. In the

worst infected countries, girls are five to six times more likely to be HIV positive than boys of the same age (UNICEF, 2004). In the last few years all the countries in the region have taken steps to address HIV/AIDS and, in particular, make efforts to reach information to women and girls so that they are able to make a realistic assessment of the danger they are in. It is in this context that education plays a critical role in enhancing the risk perception of girls and young women.

While countries in the region recognize the existence of gender-based violence, it remains a taboo subject among both educational policy programmers and health planners. This area is a 'silent zone'. The challenge in the region is to

BOX 8: COUNTRY STRATEGIES TO COMBAT HIV/AIDS

Afghanistan: The government has established an HIV/AIDS/STI control department. Focal points are in the Ministries of Religious Affairs, Education and Women's Affairs. Studies and behaviour surveys are planned. No programme in schools or specifically for girls.

Bangladesh: There is a National Policy on HIV/AIDS and a high-level national committee (NAC). Implementation through 380 NGOs and AIDS Service Organizations. Focus on high-risk groups. No specific programme in schools or for girls.

Bhutan: National HIV/AIDS and STD Control Programme (NAP) created in 1988. No specific programme in schools or with girls.

India: National Aids Control Organization (NACO) set up in 1991. Targeted interventions for high-risk groups, classification of states on prevalence, involvement of NGOs in communication and care, surveillance in MCH clinics, research studies, condom promotion, antiretroviral treatment though public health system, some efforts to deal with the stigma and nation-wide AIDS awareness through the media. However, no specific national government programmes in schools or with girls. There are, however, several initiatives in some state governments and in the non-government sector.

Maldives: The AIDS control programme started in 1987. Public education, peer education and media awareness. This is one country where 98 per cent of population is aware of HIV/AIDS and the risk of transmission. No programmes in schools or with girls.

Nepal: The National Aids Control and Prevention Programme started in 1988, national policy in 1995. Antiretroviral available. NGOs and CBOs involved. However, country is in a state of political change. Therefore, have to wait and see if the policies will change. No efforts in schools or with girls.

Pakistan: National AIDS Prevention and Control Programme (NACP) in 1987. In its early stages, the programme was focused on diagnosis of cases that came to hospitals, but progressively began to shift toward a community focus. Its objectives are the prevention of HIV transmission, safe blood transfusions, reduction of STI transmission, establishment of surveillance, training of health staff, research and behavioural studies, and development of programme management. Government has involved 54 NGOs. No programme in schools or with girls.

Sri Lanka: The National STD and AIDS Control Programme started in 1992. Focus on transmission through blood transfusion, treatment, preventive activities and surveillance among vulnerable groups (STI clinics). Ensured 100 per cent blood safety. No programme in schools or with girls.

Source: UNAIDS and World Bank, August 2006.[23]

convert it into a 'zero tolerance zone'. As of now, strategies to prevent the spread of HIV/AIDS have not been extended to schools. India is, reportedly, at a very vulnerable stage of the epidemic. The infection has crept from high-risk groups into the general population. Maternal health centre-based surveillance reveals that young married women have caught the infection. The worrisome part of this is that some of the states in India have made uninformed decisions – for example some states are planning to make HIV testing mandatory before marriage even though human rights groups and women's groups have pointed out that this is a violation of the basic rights of citizens. The obvious strategy to promote good health, nutrition and protection from HIV is to enable women and girls to identify and understand the risks of infection. Eight to ten years of education is known to enhance not only the risk perception of people but also enables them to access information and make informed choices. Support structures – neighbourhood or accessible counselling centres/clinics to help people with treatment and counselling – are the way forward.

Another issue that merits attention is trafficking of girls and women in this region. While accurate country-wise estimates are not available and also very difficult to compile, the important issue is that there is considerable evidence of trafficking of girls in India, Nepal, Bangladesh and Sri Lanka. This is a serious issue and interrupts the education of girls, puts them at high risk of violence and abuse, increases their risk exposure to HIV/AIDS and scars them for life.

3.2 An Overview of the Region

Table 3.2 captures the overall situation of health and education of girls in the region, and looks more promising than it

did in the early 1990s. Yet, the important point is that while educational programmes are targeted towards girls, health programmes are directed towards women in the reproductive age group. There is no 'school health' programme that tries to address the overall health situation of children – girls and boys. The health and nutritional situation of girls is quite precarious and there is considerable unanimity on the need to improve adolescent health in order to bring down maternal mortality. The bidirectionality of education and health – one influencing and impacting on the other – has to be followed through with programmes that take a holistic view of the overall growth and development of girls. It is artificial to separate health and education of children – and this is far more critical when it comes to girls.

Table 3.2 Promoting Health and Education of Girls: Where Do We Stand?

Level of effort to promote girls' education: Level 1 Poor ✔; Level 2 Some effort ✔ ✔; Level 3 Concerted effort ✔ ✔ ✔; Not available: n.a								
	Afghanistan	**Bangladesh**	**Bhutan**	**India**	**Maldives**	**Nepal**	**Pakistan**	**Sri Lanka**
Compulsory education	✔ ✔ ✔	✔ ✔ ✔	✔ ✔ ✔	✔ ✔ ✔	✔ ✔ ✔	✔ ✔	✔ ✔	✔ ✔ ✔
Free education up to elementary	✔ ✔ ✔	✔ ✔ ✔	✔ ✔ ✔	✔ ✔ ✔	✔ ✔ ✔	✔	✔	✔ ✔ ✔
Physical access	✔ ✔	✔ ✔ ✔	✔ ✔	✔ ✔ ✔	✔ ✔ ✔	✔ ✔	✔ ✔	✔ ✔ ✔
Encourage recruitment of women teachers	✔ ✔	✔ ✔	✔	✔ ✔	✔ ✔ ✔	✔ ✔	✔ ✔	✔ ✔ ✔
Water and separate toilets in school	✔	✔ ✔ ✔	✔ ✔	✔ ✔	✔ ✔ ✔	✔	✔	✔ ✔ ✔
School meal programme	✔	✔ ✔ ✔	n.a	✔ ✔ ✔	n.a	✔	n.a	n.a
School health programme	✔	✔	✔	✔	✔	✔	✔	✔
Iron, folic acid, nutrition and school health	✔	✔ ✔	✔	✔	n.a	✔	✔	n.a
Violence, abuse and corporal punishment	✔	✔ ✔	n.a	✔ ✔	n.a	n.a	n.a	n.a
Life skills education / HIV/AIDS education	✔ ✔	n.a	n.a	✔	n.a	n.a	n.a	n.a

Source: Adapted from Bennell (2004)

3.3 The Road Ahead

Governments are yet to realize that gender inequality in education (like in the larger society) is a result of many different levels and layers of problems. The whole gamut of educational issues – starting from the cost of education to physical access and transportation, sexual harassment, overcrowded classrooms, teacher shortages and attitudes of the teaching community – all work together to make education a tough goal for girls. Therefore, addressing a couple of problems, distributing incentives or initiating innovative programmes in a specific location will not have a long-term, sustainable impact on the system. Similarly, ensuring girls are healthy, get proper nutrition and care and are protected from abuse and violence is also contingent on how much girls are valued in the community. Therefore, distribution of iron and folic acid tablets in schools and providing nutritious meals is not sufficient to address the range of factors that affect/influence the health and well-being of girls. In many ways the two critical dimensions of human development – education and health – are closely linked. Often poor educational status is reflected in the health statistics and vice versa.

None of the countries in the region have a stated policy on promoting girls' health. They have programmes for improving reproductive and child health, but specific initiatives to promote the nutrition and health of girls in school do not appear to be an integral part of health sector programmes. Malnutrition and lack of access to health is related to poverty and the specific vulnerability of women and girls. This, in turn, has its roots in gender relations in the community. There is a need to understand the situation on the ground and recognize that:

- Regions with the lowest indicators have to make the maximum strides.
- More deprived social groups need greatest attention.
- The poor need meaningful access to government services – education, health and nutrition.
- Forging synergy, rather than competition, between sub-sectors (elementary education, adult education and literacy, maternal health, child health, HIV/AIDS, nutrition) is key within the existing reproductive and child health programmes in the region.

Therefore – as a first step – the international community and the South Asian region need to acknowledge the linkages between health and education. Many of the factors that influence both health and education are similar, while there are also significant sectoral differences – as evident in the mirror Tables 3.3 and 3.4.

Success of a holistic education and health strategy over a period of time and across a wide area or population can be

Table 3.3 What Influences Girls' Education?

Systemic issues	Content and process of education	Economy, society and culture
■ Physical access ■ Functioning schools ■ Quality of schools ■ Motivation of teachers ■ Attitudes and prejudices of teachers ■ Different kinds of schools, differentially endowed facilities ■ Calendar and timings ■ Corporal punishment	■ Gender stereotyping in school ■ Perpetuation of gender bias in books ■ Relevance of curriculum ■ Language ■ Joyful learning ■ Ready access to books, magazines, papers and so on	■ Poverty/powerlessness ■ Status of women ■ Direct and indirect costs ■ Child labour / domestic work ■ Self-esteem and self-perception ■ Health and nutrition ■ Post-puberty practices ■ Child marriage

Table 3.4 What Influences the Health and Nutrition of Girls?

The health system	Approaches, priorities, mindset and attitudes	Economy, society and culture
■ Physical access ■ Availability of healthcare facilities and providers ■ Location and timing of services ■ Quality of care and clinical skills of providers ■ Single or multiple window for interrelated services ■ Reliable referral services	■ No specific girls' health programme – focus on women in reproductive age groups ■ Resistance to providing sex education to girls ■ Attitude of healthcare providers ■ Absence of a rights perspective in health services ■ HIV/AIDS and STI	■ Poverty/powerlessness ■ Status of women ■ Poor nutrition ■ Burden of work from early age ■ Post-puberty practices ■ Child marriage ■ Domestic violence ■ Seclusion and purdah/veiling

possible only if there is both political will as well as administrative commitment. Girls' access to education can improve when there is a nationwide campaign for enrolment and increase in the number of schools. Yet, the ability of the girls to go beyond the primary level (especially in rural areas and among specific social groups/communities) depends on more than just an increased number of schools. A long-term improvement in the participation of girls hinges on their health and nutritional status and on how much they learn. It depends on the quality of education, and on the ability to effectively neutralize or address other

forms of discrimination that girls and children of ethnic/social/religious groups face. It is predicated on the opportunities they have for secondary education or post-high school vocational/technical education and training. Prevention of early marriage is a critical factor. The chance for girls to go beyond primary school depends on how effectively the direct and indirect costs of schooling can be minimized for poor and girl children in families that may be just above the poverty threshold. Ensuring that schools are absolutely free from sexual and other forms of violence and abuse is critical to the forward march of girls. This is particularly important in the light of a recent Government of India report on prevalence of child abuse in India (see Box 9).

BOX 9: GOVERNMENT OF INDIA REPORT ON CHILD ABUSE, 2006

The recent report brought out by the Government of India, Ministry of Women and Child Development, has, for the first time, documented the prevalence of child abuse, including violence in schools. The report has come out with startling findings:

- Two out of every three children are physically abused.
- Out of the 69 per cent physically abused in 13 sample states, 54.68 per cent were boys.
- Over 50 per cent of children in all the 13 sample states were being subject to one or another form of physical abuse; 88.6 per cent were physically abused by parents.
- 65 per cent of school-going children reported facing corporal punishment – two out of three children were victims of corporal punishment, a majority of them in government and municipal schools.
- 53.22 per cent children reported having faced one or more forms of sexual abuse – 5.69 per cent were sexually assaulted.
- Every second child reported facing emotional abuse, both boys and girls.
- 50.2 per cent of children reported they worked seven days a week – this includes children formally enrolled in school.
- Most children did not report the matter to anyone.

This study interviewed 3163 children who were enrolled and attending school. In all age groups, an overwhelming majority reported being beaten up at school. Out of those reporting corporal punishment in schools, 54.28 per cent were boys and 45.72 per cent were girls.

Source: GoI Report on Child Abuse (2007). www.wcd.nic.in.

It *is* possible to counter the HIV/AIDS pandemic, provided schooling integrates life skills, knowledge about sexual and reproductive health issues, human rights and child rights with academic subjects. Girls who attend school need to be treated with dignity and respect, so that they emerge from the schooling system confident and positive people. Schools must actively promote gender equality and challenge negative gender stereotyping. Adolescent programmes must address power dynamics in sexual relationships so that girls and boys can handle peer pressure for certain kinds of behaviour that comes from negative stereotyping.

This is a big challenge in South Asia because the social and cultural setting is such that political and social leaders shy away from talking about sexual activity among the young. They are wary of acknowledging the existence of sexual violence and abuse in schools and outside on young people and children. It is in this context that it is noteworthy for India to have brought out for the first time an official report on child abuse. This has generated a lot of interest in the media, in schools and in the community. Acknowledging the existence of violence and abuse is the first step towards preventing it. Similarly, efforts made in the region – especially in Nepal and Bangladesh – to curb trafficking of children are also beginning to show some results.

Existing data and prevailing indices do not tell us very much about the status of girls' education and health. There are inherent limitations in the indicators that are used in the region (as evident in Box 10). As a result, it is not possible to make a thorough analysis of what the situation of girls is in different regions, different social groups and different circumstances. It would be valuable to gather data from the community and capture the kinds of educational opportunities that are being availed of by different social and economic groups and the choices made by parents for their daughters and sons. Triangulating 'system statistics' with community-based statistics could enable us to capture gender and social equity issues.

Given the enormity of the problem and prevailing inequalities, there is need for a larger political consensus on prioritizing things that must be done immediately, in the medium term and in the long term. It is important to recognize that service providers in the government and the private sector not only need skills and training but also an environment conducive to their work. A lot has to be done to change the prevailing attitudes and prejudices, particularly in the context of HIV and AIDS.

The broad issues of gender inequality may be common to most countries in the region, but there are wide variations on how they manifest on the ground. The important thing here is that women's mobility, early marriage, preference for a male child, sex ratios and other such issues do not affect women alone. They also impact the institutional environment, leading to professional inequality where

BOX 10: WHAT THE GENDER PARITY INDEX REVEALS AND DOES NOT REVEAL

The **Gender Parity Index** (GPI) is the female to male ratio in enrolment/participation in schools. It is a measure that tells us about the number of boys and girls who are enrolled in / attending recognized schools at a particular point of time. This does not include qualitative indicators like learning or transition from one grade to the next. It is a snapshot at a particular time in a particular kind of school. It, therefore, does not capture the difference in enrolment ratios of boys and girls in private schools and government schools. It is different from gender **equality** and does not measure progress towards gender equality. It only tells us the ratio of girls to boys. Gender **equity** encompasses both parity and equality. The concepts need to be understood when we try and measure progress towards social equity and justice goals.

The **Gender-related Development Index** (GDI) is a composite index using life expectancy at birth to capture health, adult literacy and combined primary, secondary and tertiary enrolment ratios to capture education.

The **Gender Empowerment Measure** (GEM) captures relative empowerment of males and females, women's participation in political decision-making (share in parliamentary seats), women's access to professional opportunities (percentage share among legislators, senior officials, managers and percentage share among professional and technical workers) and women's earning power.

The important issue in the region is that **progression from gender parity to gender equality cannot be achieved with increased supply (of schools, health centres, hospitals) alone.** The movement to gender equality is possible only when governments and other civil society organizations proactively intervene to remove the barriers that impede access.

Source: Compiled by the author.

some cadres are less resourced in some sectors than others. Equally, issues of safety and security affect women providers more in some areas than others. For instance, in the health sector women workers are, often, at the bottom of the hierarchy. They not only lack skills, but also the confidence to reach out, move around and facilitate a change in attitudes and practices of the community.

3.4 Recommendations

Promote a holistic approach to the health, nutrition and education of girls

The overarching recommendation is to actively promote a holistic approach to nutrition, health, education, violence and socio-cultural issues that influence the overall well-being of girls. *Equally there*

is a need to promote a systemic, mainstream effort to integrate gender concerns into the very fabric of the education and health delivery system. This paper argues that these domains are inextricably intertwined and unless policy makers recognize the importance of looking at them as a continuum, it will not be possible to break out of the vicious cycle of deprivation and exclusion.

Four core programme attributes directly influence access and, hence, the utilization of services – availability, range, cost and quality. Since health and educational inequity, in turn, is concerned with differential rates of service utilization, these attributes may be considered as actionable determinants of equity:

a. Improve health and nutrition of girls:

- Intensify community education and empowerment programmes;
- Enhance the availability of women providers/volunteers – especially in countries and areas that are marked by sharp gender inequalities and social seclusion of women;
- Move services closer to girls/women – schools, healthcare providers, supplementary nutrition, iron and folic acid supplements, etc.;
- Make services responsive and accountable.

b. Improve the educational status of girls:

- Intensify community education and empowerment programmes;
- Promote community-based structures that can monitor/support schools;
- Consciously create and expand the pool of educated and trained women who can be absorbed in the public services where there is a dearth of women workers – especially in health, education, community development, local governance;
- Appoint more women teachers in schools in areas where seclusion is the norm, gender inequalities are severe and girls are withdrawn from school after puberty;
- Improve access to schools right up to the secondary stage – noting that at least eight to ten years of education is essential to bring about significant change in the capabilities of girls to make informed choices and negotiate the world with confidence.

c. Reduce economic barriers by providing free or subsidized services to girls – especially those from poor families/ communities:

- Provide subsidized/free education for girls up to the secondary level;
- Make available stipends and scholarships;
- Ensure free or subsidized residential facilities and transportation as required, to enable girls from remote/ rural areas to pursue their education;
- Supply nutritious meals in school, textbooks and educational materials; and in the case of older girls provide uniforms.

d. Introduce concrete mechanisms to make the health and educational system accountable and responsive to the needs of girls and women:

- Empower Village Education Committees / Mothers' Committees to

supervise, monitor and also provide support;
- Link the education committees to health committees that can monitor, support and supervise;
- Empower habitation level committees / local self-government institutions to play a proactive role in monitoring availability and quality of services.

The above interventions need to be initiated and sustained at four levels (see Table 3.5):

a. Policy and planning levels:
- These comprise legal, regulatory and policy measures, including measures at the macro level, to enhance or re-deploy resources for enhancing gender equity.

b. Programme level:
- This comprises management, including resource deployment and oversight functions.

c. Family and community levels:
- These include 'demand-side' actions for facilitating change in the utilization of health services.

d. Service level:
- This consists of the interface at which measures to mainstream gender result in positive outcomes. Actions at the first three levels should lead to outcomes at this level.

What is really critical in South Asia is to create a nurturing environment for people who are working at the grassroots. It is important to give positive feedback at the right time – disseminating successful experiences, affirmation and friendly and constructive criticism. Equally important is to enhance the capacity of teachers and care givers to monitor the health of children. All these go into sustaining the process long enough for it to leave a lasting impact.

This region – like the rest of the world – is used to time-bound projects and programmes. Lasting social change takes time to take root and bring about sustained change. It is, therefore, necessary to take a multi-dimensional view and design interventions that can turn around even the most difficult situation. What the region needs is long-term systemic interventions in the area of child development, education and mainstreaming gender issues into all the existing programmes in health, education and child development.

Table 3.5 captures the critical elements that go into each category.

Table 3.5 Operational Framework to Promote Health and Education of Girls[24]

Attributes	Enhancing availability of teachers, health workers, child health / nutrition workers	Bring services closer to girls	Reducing economic barriers	Making services responsive and accountable
Service delivery	- More teachers, nutrition educators and health workers - Community-level workers who can interface between society and the system	- Schools closer to home – right up to the secondary level - Hospitals and health centres closer - Supplementary nutrition and preventive health programmes	- Free/subsidized opportunities/ services to the poor - Community-based fund for families in distress	- Trained and active women's groups, adolescent groups and children's forums
Family & Community	- Community extends support/security to women teachers, healthcare providers - HIV/AIDS support groups in the community	- Mapping of available transport, schools, health facilities and care providers, especially for HIV/AIDS - Community education and participation in managing/ supervising schools, health and nutritional services	- Link women's micro-credit groups - Link health insurance with schooling	- Community education - Quarterly feedback studies that are presented and discussed in community forums - Community education on rights – corporal punishment, gender-based violence, HIV/AIDS
Programme management and oversight	- Revisit norms for location of schools and health centres, nutritional supplement programmes, etc.	- Performance appraisal of institutions and services – one that involves girls/women and people from extremely disadvantaged/ deprived social groups	- Revisit/review user fees and other paid services; - Provide subsidies to the poor, to families affected by HIV/AIDS	- Conduct social audit of educational programmes, including learning outcomes in schools; health programmes and nutritional outreach services - Make them public and discuss them in community groups
Policy & Planning	- Gendered human resource policy for frontline workers - Budget allocations for increasing availability of teachers and healthcare providers - Reduce qualifications where necessary	- Context-specific norms to be developed – tribal areas, mountainous and desert regions may need different norms - Specific norms for HIV/AIDS affected communities/families	- Create book banks, medicine banks and support for poor - Stipend programmes for girls for lower secondary and secondary education	- Six-monthly review of results of social audit, feedback studies, etc. - Budget allocation for enabling adolescents, HIV/AIDS-affected families and marginalized communities to negotiate healthcare and continuing education

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NOTES

1. The available literature is vast and rich – recent efforts to compile existing evidence are: (i) Hulton, L. with Furlong, D. (2001). *Gender Equality in Education: A Select Annotated Bibliography*. University of Sussex, UK: BRIDGE; (ii) Wellesley Centre for Research on Women (2005). *Unsafe Schools: A Literature Review of School-related Gender-based Violence in Developing Countries*. USAID; (iii) Herz, B. and Sperling, G.B. (2004). *What Works in Girls' Education – Evidence and Policies from the Developing World*. New York: Council for Foreign Relations; (iv) Ramachandran, V. (Ed.) (1998). *Bridging the Gap between Intention and Action – Girls' and Women's Education in South Asia*. Bangkok and New Delhi: UNESCO-PROAP and ASPBAE; (v) UNICEF (2003). *The State of the World's Children Report 2004. Girls' Education and Development*. New York: UNICEF; (vi) Background papers prepared for *EFA Global Monitoring Report, 2003/04, Gender and Education for All: The leap to equality*, Paris: UNESCO.
2. Preamble to the Constitution of the World Health Organization, 1948, cited by Bloom (2005).
3. 'Undernutrition was strongly associated, both in the review of published work and in new analyses, with shorter adult height, less schooling, reduced economic productivity, and – for women – lower offspring birthweight. Associations with adult disease indicators were not so clear-cut. Increased size at birth and in childhood were positively associated with adult body-mass index and to a lesser extent with blood pressure values, but not with blood glucose concentrations. In our new analyses and in published work, lower birthweight and undernutrition in childhood were risk factors for high glucose concentrations, blood pressure, and harmful lipid profiles once adult body-mass index and height were adjusted for, suggesting that rapid postnatal weight gain – especially after infancy – is linked to these conditions. The review of published works indicates that there is insufficient information about long-term changes in immune function, blood lipids, or osteoporosis indicators. Birthweight is positively associated with lung function and with the incidence of some cancers, and undernutrition could be associated with mental illness. We noted that height-for-age at 2 years was the best predictor of human capital and that undernutrition is associated with lower human capital. We conclude that damage suffered in early life leads to permanent impairment, and might also affect future generations. Its prevention will probably bring about important health, educational, and economic benefits. Chronic diseases are especially common in undernourished children who experience rapid weight

gain after infancy …' (Victora, C.G. *et al.* for the Maternal and Child Undernutrition Study Group, 2008).

4. Source: http://mohfw.nic.in/NFHS-3%20Nutritional%20Status%20of%20Children.ppt , accessed by the author on15 March 2008.
5. *The Lancet* published a landmark series of papers on Maternal and Child Undernutrition in 2008. Produced and distilled though the combined knowledge and expertise of academics and agencies, including experts at World Health Organization, these papers will serve to catalyse the international community to bring nutrition more squarely onto the global agenda. The papers bring to bear evidence on the critical role of early nutrition in the health of children, making clear that the golden period of intervention for nutrition is between pregnancy and 24 months. Source: http://www.who.int/nutrition/topics/lancetseries_maternal_and_childundernutrition/en/index.html accessed by the author on 15 March 2008.
6. *The Lancet*: Executive Summary of The Lancet Series on Maternal and Child Undernutrition, 2008.
7. This is a part of the UNICEF's *Strategy for Improved Nutrition of Children and Women in Developing Countries* first published in 1990.The two key features of this strategy are a method for assessment, analysis and action related to nutrition (Triple A cycle) and this conceptual framework to guide the analysis of the causes of malnutrition in a given context.
8. Filmer (2003) reports that a longitudinal study in Pakistan found that a one-third of a standard deviation increase in a child's height increased school enrolment by 19 percentage points for girls and 4 percentage points for boys.
9. http://www.hrw.org/0913school.htm.
10. The key sources are: UNAIDS (2003). *Epidemic Update*. New York. www.unaids.org; Malhotra *et al.* (2003). *Impact of Investment in Female Education on Gender Inequality*. Washington DC: ICRW; Vandemoortlele and Delamonica (2000). Education Vaccine against HIV/AIDS. *Current Issues in Comparative Education*, 3(1); UNAIDS (2007) newsletter from www.womenandaids.unaids.org; Jukes (2006); and UNAIDS Website 2007.
11. 'A global review of child deaths by the Bellagio Child Survival Group showed that 34 per cent of child deaths occur in South Asia and that the region has almost two-thirds of the global burden of malnutrition. Of an estimated half a million maternal deaths worldwide, almost half occur in South and Southeast Asia. Maternal mortality ratios range from 23/100,000 live births in Sri Lanka to 539/100,000 in Nepal' (Bhutta *et al.*, 2004).
12. The sex ratio among the first-baby group is quite normal but it increases abruptly among the second-baby group, and it is much higher among the third-baby group according to the report. Although sex-selective abortion is strictly forbidden by the government it is reported that some families seeking sons still take risks, especially in rural areas. In 1993 and 1994, more than 121 boys were born in China for every 100 baby girls. (The normal ratio at birth is around 105; for reasons debated among biologists, humans seem naturally to churn out slightly more boys than girls.) In India during the period 1996 to 1998, the birth ratio was 111 to 100; in Taiwan in 2000, it was 109.5. In 1990 a town near New Delhi reported a sex ratio at birth of 156. Source: Hudson and den Boer (2004) and http://app1.chinadaily.com.cn/star/2002/1024/fo5-1.html.
13. However, the small sample sizes in high-risk groups may not give an adequate picture of the epidemic among populations most likely to experience a rise in HIV prevalence. UNAIDS estimates that about 500 people could have been living with HIV at the end of 2005.
14. With regard to parents' attitude towards girls' education, findings from quantitative data indicate that more than half, 64 per cent, of the respondents show no gender preference for school enrolment. However, 27 per cent of parents feel preference should be given to boys while 9 per cent believe girls should be given preference. It appears that the three most remote sites (Damji, Jurmey and Pantang) have stronger preference for boys to be educated … Although results of the general survey data indicate no strong gender preference for school enrolment, all focus group discussions reveal a strong preference for boys. Reasons for preference being that *'boys are more independent, capable, mobile and better at studies'*, while girls were less capable

of going out and better at housework. So, when a choice between a boy and girl had to be made for enrolment, it was the girl who stayed behind. Other reasons for influencing parents' attitude are the traditional belief that girls will be taken care of by their husbands while the sons have to sustain themselves and their families when they marry. Further, many parents were of the opinion that educating boys is a sound investment as they can get employment more easily than girls … Parents from Pantang quoted the example of the only two girls to have partially completed high school to date from their area and unfortunately both girls have not been able to get employment. Such facts have a negative influence on parents' attitude towards girls' education … (UNICEF Bhutan, 2003).

15. Source: NFHS INDIA, http://www.nfhsindia.org/summary.html, March 2007.
16. NSS Round 58 Consumer Expenditure, Round 60 Consumer Expenditure and Health Care and 61 Round on Consumer Expenditure and Employment and Unemployment.
17. The number of actual HIV/AIDS cases in India might be millions fewer than current estimates, according to a new, unreleased household survey. UNAIDS estimates from 2006 show that there are about 5.7 million people living with HIV/AIDS in India. However, a preliminary analysis of the National Family Health Survey – which was conducted under international supervision and with U.S. funding – suggests that India has between two million and three million people living with HIV/AIDS, according to several sources, including U.S. epidemiologists and the Indian Ministry of Health and Family Welfare. The survey concluded last year (*Source: Kaiser Daily HIV/AIDS Report, 6/11*). The new estimate was calculated with the assistance of international agencies, such as the United Nations and USAID. According to press reports the earlier estimate was based on blood samples taken from pregnant women and high-risk groups, such as injection drug users and commercial sex workers. The new estimates are based on a population-based survey that took blood samples from 102,000 people to determine HIV prevalence among the general population. Population-based surveys are 'more representative' and yield 'more accurate information' for rural areas and for the male population, UNAIDS said. (*Reuters report cited in national newspapers of India on 7 July 2007*.)
18. The results from the 2005 BBC World Service Trust KAP survey (17 states, 22,800 respondents) showed that 89 per cent of the urban population and 82 per cent of the rural population had heard of HIV/AIDS. However, sentinel site behavioural surveillance (2001) showed that although there were high basic awareness levels (82.4 per cent in males and 70 per cent in females), rural women demonstrated very low rates of awareness in Bihar (21.5 per cent), Gujarat (25 per cent) and Uttar Pradesh (27.6 per cent). New approaches need to be tried to reach rural communities with information about HIV/AIDS, safe sex and how to prevent and treat HIV/AIDS. *Source:* World Bank (2006).
19. UNICEF website, www.unicef.org/infobycountry/pakistan_pakistan_background.html, accessed on 15 March 2008.
20. Jomtien refers to the first EFA conference held in Jomtien, Thailand in 1990.
21. Jukes (2006) has cited two studies by Green (1984) and Pharaoh and Connolly (1987).
22. http://siteresources.worldbank.org/NEWS/Resources/Bangladesh-education-text.pdf.
23. http://go.worldbank.org/NWLDBZF2G0.
24. This matrix has been adapted from an unpublished mimeograph of ARTH and Ramachandran, V. (2004). *Mainstreaming Gender in India's Reproductive Health Programme*. New Delhi: UNFPA India Country Office.

ANNEX
TABLES AND CHARTS

Table A.1 Girls' Education: Barriers and Potential Benefits

Issues	Barriers	Benefits
Economic	- Cost – direct and indirect - Opportunity cost (lost chore time and loss of family income) - Migration and displacement - Household labour and survival	- Acquire information and skills - Employment / self employment - Higher income/wages - Manage money/credit - More productive farming
Geographical	- Location and access; roads and basic infrastructure - Physical safety - Transport availability and cost	- Gain confidence to go beyond one's habitation/village/settlement - Increased mobility
Social	- Patriarchy - Lack of mobility - Early marriage, dowry - Low status - Dearth of role models - Marginalization of community	- Can delay marriage - Break inter-generational cycle of low education in family - Economic benefits to family can change mobility norms - Role model in family
Culture and religion	- Discrimination and stereotyping (affects self-esteem and confidence) - Seclusion practices prevalent in many communities like the practice of women wearing purdah or ghunghat, not permitting women to go out in public spaces	- Isolation and seclusion transcended when going to school - Family weighs benefits against social norms and traditional practices

Issues	Barriers	Benefits
	- Fundamentalism in religious interpretation and caste norms - Role of son in rituals	
Family	- Family size – number of siblings, childcare, workload - Take care of old/ill - Care for cattle/animals - No academic support at home	- Positive impact on siblings and daughters - Confidence to access ECE/childcare - Support children/siblings in education
Gender relations	- Value of girl child - Gender role stereotypes - Preference for son - Impacts nutrition and health of girls	- Question stereotypes and assert oneself
Violence	- Domestic violence - Health risks, fear and shame - Low self-esteem and confidence - Sexual abuse and violence on the way to and in school	- May gain confidence to resist violence at home - Seek help – medical and social; seek counselling
The school	- Unfavourable school environment - Female teachers - Quality, relevance and learning - Corporal punishment - Verbal/physical harassment/abuse	- Greater participation of girls increases confidence of family - Safety in numbers - More educated women in family and community have ripple effect
Health	- Malnutrition - Communicable diseases - Frequent bouts of illness - Lack of clean water - No toilets/sanitation - Disability	- Personal and family hygiene improves - Better nutrition practices - Seeking healthcare more proactively - Protect against disease
HIV and AIDS	- Care of infected family members – increased workload - Ignorance leading to being infected - Stigma and prejudice	- Protect oneself – knowledge - Greater risk perception - Self-confidence to negotiate / say no
School-related gender based violence (SRGBV)	- Fear of attending school - Shatters self-esteem and confidence - Parents withdraw girls for fear of sexual harassment / rape	- Addressing SRGBV and taking steps to curb it can enhance the confidence of family/community to send girls to school

Source: Generated by the author from a wide spectrum of research-based studies listed in the bibliography

Table A.2 Basic Health Indicators, South Asia

Countries	Under-5 mortality rate		Infant mortality rate (under 1)		Neonatal mortality rate	Annual no. of births (thousands)	Annual no. of under-5death (thousands)	GNI per capita (US$)	Life expec-tancy at birth (years)	Maternal mortality rate		
	1990	2005	1990	2005	2000	2005	2005	2005	2005	1990 – 2005	2000	Lifetime risk of maternal death 1 in:
										Reported	Adjusted	
Afghanistan	260	257	168	165	60	1441	370	250	47	1600	1900	6
Bangladesh	149	73	100	54	36	3747	274	470	64	320	380	59
Bhutan	166	75	107	65	38	64	5	870	64	260	420	37
India	123	74	84	56	43	25926	1919	720	64	540	540	48
Maldives	111	42	79	33	37	10	0	2390	67	140	110	140
Nepal	145	74	100	56	40	787	58	270	62	540	740	24
Pakistan	130	99	100	79	57	4773	473	690	64	530	500	31
Sri Lanka	32	14	26	12	11	329	5	1160	74	43	92	430

Source: SOWC, UNICEF (2007)

Table A.3 Percentage of Under-Five Children who are Underweight

	Year	Age (months)	Male	Female	Urban	Rural
Afghanistan (a)	2003/04	6–59	38	40	47	50
Bangladesh (b)	2004	0–59	46	49	42	49
Bhutan (c)	1999	6–59	20	17	–	–
India (d)	1998/99	0–35	45	49	38	50
Maldives (e)	2001	0–59	31	30	–	–
Nepal (f)	2001	0–59	46	51	33	49
Pakistan (g)	2001/02	0–59	38	36	35	39
Sri Lanka (h)	2000	3–59	29	30	19	32
South Asia			44	47	38	48
World			26	26	18	33

Source: SOWC, UNICEF (2007)
(a) National Micronutrient Survey 2004, Tables 5.1-5.3 (gender); Multiple Indicator Baseline 1997, UNICEF and CIET (age adjusted) (residence)
(b) Gender 2004, residence 1997, DHS 2004, Final report, Table 23, p. 33
(c) National Anthropometric Survey of Under-Five Children in Bhutan 1999, Ministry of Health, Division of Health Services, with additional analysis by WHO
(d) National Family Health Survey (NFHS) 1998/99
(e) MICS 2001, Table 5.5
(f) DHS 2001, pp. 188
(g) National Nutrition Survey 2001-02, Final report (Draft), pp.41–2
(h) DHS 2000, Final report, p. 200

Table A.4 Gender Gaps in Literacy and Education

Countries	Female adult (15+) literacy rates GMR 07	Adult literacy rate: females as a % of males	Enrolment rates: females as a % of males			
			Primary school 2000–2005		Secondary school 2000–2005	
	2000–2004	2000–2004	Gross	Net	Gross	Net
Afghanistan (2006)	18	36	60	–	35	–
Bangladesh	51.7	–	104	103	110	113
Bhutan	–	–	–	–	–	–
India	47.8	66	93	95	80	–
Maldives	96.4	100	97	101	115	115
Nepal	34.9	56	92	88	86	–
Pakistan	36	57	73	74	74	–
Sri Lanka	89.1	97	99	99	101	–
South Asia	59	64	91	93	83	–

Source: SOWC, UNICEF (2007)

Table A.5 Basic Educational Indicators

Countries	Primary school enrolment rate 2000–2005				Primary school attendance rate 1996–2005		% of primary school entrants reaching Grade 5		Secondary school enrolment rate 2000–2005		Secondary school attendance rate 1996–2005		
	Gross		Net		Net		Admin. Data	Survey data	Gross		Net		
	M	F	M	F	M	F	2000–2004	1997–2005	M	F	M	F	%F
Afghanistan (2006)	151	92	–	–	67	40	–	92	25	7	18	6	16
Bangladesh	107	111	92	95	82	86	65	87	49	54	33	41	51
Bhutan	–	–	–	–	73	67	91	–	–	–	–	–	45
India	120	112	92	87	79	72	79	95	59	47	54	46	43
Maldives	105	102	89	90	–	–	99	–	68	78	15	11	52
Nepal	118	108	83	73	80	67	61	92	49	42	–	–	45
Pakistan	95	69	76	56	62	51	70	90	31	23	–	–	41
Sri Lanka	102	101	99	98	–	–	–	–	82	83	19	20	49

Source: SOWC, UNICEF (2007) and GMR, UNESCO (2007)

Table A.6 HIV/AIDS in South Asia

	Adults and children 2005		Adult (15–49) rate (%) 2005		Women (15+) 2005	
Country	Estimate	[Low estimate – high estimate]	Estimate	[Low estimate – high estimate]	Estimate	[Low estimate – high estimate]
Afghanistan	<1000	[<2000]	<0.1	[<0.2]	<100	[<1000]
Bangladesh	11,000	[6400 – 18,000]	<0.1	[<0.2]	1400	[710 – 2500]
Bhutan	<500	[<2000]	<0.1	[<0.2]	<100	[<200]
India	5,700,000	[3,400,000 – 9,400,000]	0.9	[0.5 – 1.5]	1,600,000	[820,000 – 2,800,000]
Maldives	–	–	–	[<0.2]	–	–
Nepal	75,000	[41,000 – 180,000]	0.5	[0.3 – 1.3]	16,000	[7500 – 40,000]
Pakistan	85,000	[46,000 – 210,000]	0.1	[0.1 – 0.2]	14,000	[6600 – 36,000]
Sri Lanka	5000	[3000 – 8300]	<0.1	[<0.2]	<1000	[<1000]

Source: UNAIDS (2006) http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH03_en.pdf

Table A.7 Regional Comparisons

	HDI Value 2004	Life expectancy at birth (years) 2004	Adult female literacy as a percentage of males 2000–2004	Gross enrolment ratio for primary, secondary and tertiary 2004	GDP per capita (PPP US$ 2004)
Arab States	0.680	67.3	74.0	62	5,680
East Asia and the Pacific	0.760	70.8	91.0	69	5,872
Latin America and the Caribbean	0.795	72.2	98.0	81	7,964
South Asia	0.599	63.7	64.0	56	3,072
Sub-Saharan Africa	0.472	46.1	76.0	50	1,946
Central and Eastern Europe and the CIS	0.802	68.2	97.0	83	8,802

Source: HDR, UNDP (2006)

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Vimala Ramachandran specializes in elementary education, girls' education and women's empowerment issues. She has extensive experience in qualitative research, programme development and process documentation. She was the first National Project Director of Mahila Samakhya (1988-93) – a Government of India programme based in the Department of Education, MHD. She established the Educational Resource Unit – a network of researchers and practitioners working on elementary education, women's education and empowerment. She is also the founder Trustee of HealthWatch, a network of NGOs, researchers and individuals working in the area of women's health and gender, population and development issues. She has published extensively on primary education, girls' education and women's empowerment and writes periodically in professional journals and daily newspapers.

WAYS IN WHICH HEALTH AFFECTS EDUCATION OF GIRLS

- Impairs mental and cognitive development
- Affects motor development
- Affects emotional health
- Exacerbated by frequent bouts of illness

Under-nutrition (Protein energy malnutrition)

- Affects psychomotor development
- Weak, listless, irritable, susceptible to illness
- Gender differences in food and care
- Affects adolescent girls

Iron deficiency and anaemia

- Brain development affected by deficiency
- Hypothyroidism leads to mental retardation

Iodine deficiency

- Causes weakness, aggravates malnutrition
- Affects cognitive development
- Hookworm leads to anaemia

Worm infection

Tuberculosis, malaria, meningitis, scabies, gastrointestinal diseases

- Frequent bouts of illness
- Cognitive impairment
- Skin diseases affect self-esteem and confidence
- Long-term behavioural problems

HIV/AIDS and school

- Stigma
- Children withdrawn
- Schools discriminate
- Scepticism and fatalism
- Education system not prepared as yet
- Teacher attrition

HIV/AIDS and children

- Poor have no access to ART
- Children orphaned
- Children with AIDS likely to have lost a parent
- Depression and helplessness
- Social stigma

Corporal punishment, and gender-based violence in school

- Cognitive development affected
- Child withdraws and does not participate
- Low self-esteem
- Feeling of shame and guilt
- Physical injuries, pregnancy

Violence and child abuse

- Impacts the maturing brain
- Social, emotional and cognitive impairment
- Anxiety, depression, aggressive behaviour
- Eating and sleeping disorders
- Feeling of shame and guilt
- Physical injuries, pregnancy
- Reproductive health problems
- Attempts at suicide

GIRLS' EDUCATION: BARRIERS AND POTENTIAL BENEFITS

ECONOMIC

Direct & indirect fees, cost of books and supplies

Migration: seasonal and long-term

Displacement

Household labour and survival

Paid work: seasonal and regular

POTENTIAL BENEFITS

Acquire information and skills for livelihood

Higher income

Increased productivity

Manage money / credit

Employment in formal / informal sector

GEOGRAPHICAL

Location and access; roads and basic infrastructure

Physical safety, transport availability and cost

POTENTIAL BENEFITS

Gain confidence to go beyond one's habitation / village / settlement

Increased mobility

SOCIAL AND GENDER RELATIONS

Marginalization of community (caste, tribe, religion, occupation)

Dearth of role models

Early marriage, dowry

Lack of mobility, purdah, seclusion

Partilocal residence

Value of girl child and son preference

Gender stereotypes

POTENTIAL BENEFITS

Can delay marriage

Break inter-generational cycle of low education in family

Economic benefits to family can change mobility norms

Role model in family

Question stereotypes and assert oneself

CULTURE AND RELIGION

Discrimination and stereotyping (affects self-esteem and confidence)

Fundamentalism in religious interpretation and caste norms

Role of son in rituals

POTENTIAL BENEFITS

Isolation and seclusion transcended when going to school

Family weighs benefits against social norms and traditional practices

FAMILY

Family size: number of siblings and childcare load

Take care of old / ill

Care for cattle / animals

Illiteracy and low education

No academic support at home

POTENTIAL BENEFITS

Positive impact on siblings and daughters

Confidence to access ECE / child care

Support other children in education

VIOLENCE

Domestic violence

Health risks, fear and shame

Low self-esteem and confidence

Sexual abuse and violence on the way to and in school

POTENTIAL BENEFITS

May gain confidence to resist violence at home

Seek help: medical and social; seek counselling

THE SCHOOL

Unfavourable school environment

Quality and relevance

Corporal punishment

Verbal / physical harassment / abuse

Lack of gender awareness among teachers

POTENTIAL BENEFITS

Greater participation of girls increases confidence of family

Safety in numbers

More educated women in family and community have ripple effect

LEARNING

Not learning much and repeated failure not motivated to stay

Language barrier to learning

POTENTIAL BENEFITS

Ability to learn enhances self-esteem and confidence

Can teach their children / siblings

HIV AND AIDS

Care of infected family members increases workload

Ignorance leading to being infected

Stigma and prejudice

POTENTIAL BENEFITS

Protect oneself; knowledge

Greater risk perception

Self-confidence to negotiate / say no

SCHOOL-RELATED GENDER-BASED VIOLENCE

Fear of attending school

Shatters self-esteem and confidence

Parents withdraw girls for fear of sexual harassment / rape

POTENTIAL BENEFITS

Addressing SRGBV and taking steps to curb it can enhance the confidence of family / community to send girls to school

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