

## **Unmet Reproductive and Sexual Health Needs in South Asia**

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*The magnitude of reproductive and sexual health problems in South Asia is daunting. However, an enabling policy environment provides an opportunity to address unmet needs. Neglected reproductive health problems can be effectively addressed through a life-cycle approach. The paper underscores interlinked gender, sexuality and rights concerns within which these problems are embedded.*

*Key words: South Asia; reproductive health; sexual health; unmet needs*

### **Global Consensus on Reproductive and Sexual Health**

At the 1994 International Conference on Population and Development (ICPD) in Cairo, the world community effectively wrote a new agenda for population and development to serve as the blueprint for population programs internationally and nationally for the next twenty years. ICPD placed the population problem squarely within the development context focusing particularly on quality of life, human rights and women's empowerment.

At Cairo, the nations of the world agreed that governments should give special attention to the health of women, the survival of infants and young children, the education of girls, and in general, the empowerment of women. At the same time they should provide comprehensive reproductive health services to enable couples to achieve their reproductive goals, and determine freely and responsibly the number and spacing of their children. The ICPD consensus implies that if governments ensure that this basic package of social policies and reproductive health services is in place they will simultaneously make strides toward greater social equity and reducing high rates of population growth (Sinding and Fathalla 1995: 18-21).

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Consensus on the ICPD Program of Action provides the foundation for practical progress towards a number of interrelated sustainable development objectives. However, to achieve these objectives, many unmet needs must be addressed. Several of these can be effectively met only if :

- population agencies move beyond family planning as their main program mechanism and collaborate much more closely with health and development agencies;
- development sectors integrate population-related and human rights concerns into their policies and programs;
- communities and governments come to terms with imbalances in power and opportunities between the state and its people, between providers and users of services, and between men and women; and
- governments foster participatory processes that give leadership and responsibility to communities, non-government organizations (NGOs), and the larger civil society.

### **Translating Reproductive and Sexual Health Rhetoric into Reality**

While the global acknowledgment of reproductive and

sexual health has brought much satisfaction and a sense of achievement to many who worked for well over a decade to help develop the new paradigm articulated at ICPD, it has also thrown up fresh challenges. A major challenge confronting governments now is how to translate reproductive and sexual health concepts into policies and programs within national contexts.

To translate reproductive rhetoric into reality, two priority issues must be addressed. First, it is essential to make a conceptual shift. Second, packages of good quality services must be designed and implemented to address reproductive and sexual health needs of clients. Clients have multiple needs, many of which are unmet, especially in South Asia, a particularly deprived region. An important priority is to design programs that are truly responsive to the needs of the clients. In this paper unmet reproductive and sexual health needs in South Asia are defined and discussed with some reference to programs. A discussion of implementation of program strategies to address these needs is not within the scope of this analysis.

### **South Asia Within a Global Context**

With a share of 22 percent of the world's people, South Asia is inhabited by 40 percent of the world's absolute poor and is now the poorest region of the world. Its per capita income of \$309 is far below that of \$555 of Sub-Saharan Africa and \$970 for all developing countries. Its adult literacy of 48 percent is below 55 percent of Sub-Saharan Africa and 98 percent of East Asia (excluding China) (Table 1). About one-half of the world's illiterate people live in South Asia. Neglect of basic social services is related to poverty in South Asia. The World Bank estimates that some this region contains approximately 40 percent of the world's absolute poor, surviving on less than one dollar a day. Far more crippling than income poverty is the poverty of basic human capabilities, which prevents people from taking advantage of market opportunities. Nearly two-thirds of the population in South Asia is deprived of basic human capabilities, compared to just over one-quarter which is deprived of a minimum income. This makes the task of poverty elimination doubly difficult (UNDP 1996).

The impact of deprivation is greatest on women and children. The maternal mortality rate in South Asia is about 600 per 100,000 live births. It is as high as 850 in Bangladesh,

1,500 in Nepal, and 1,600 in Bhutan. These are among the highest maternal mortality rates in the world, when compared to a rate of only 28 in industrial countries. Despite its much higher GNP growth rate and its more robust increase in food production, South Asia has more malnourished children than Sub-Saharan Africa. Almost two-thirds of children in South Asia are underweight, compared to one-sixth in Sub-Saharan Africa. Approximately one-third of all babies in India and one-half in Bangladesh are born with low birth weight. In Sub-Saharan Africa, the proportion is about one-sixth (UNICEF 1996).

**Table 1** Comparative Education and Health Profile for South Asia, East Asia, Sub-Saharan Africa and Developing Countries

	South Asia	East Asia (excl. China)	Sub-Saharan Africa	All Developing Countries
<b>Education Profile</b>				
Adult literacy (%) 1993	34	94	45	60
1st, 2nd and 3rd level gross enrollment ratio (%) 1993	43	76	37	51
Mean years of schooling 1992	1.2	6.2	1.3	3.0
<b>Health Profile</b>				
Female life expectancy 1993	61	75	53	63
Maternal mortality rate per 100,000 live births 1993	585	100	929	384
Total fertility rate 1993	4.2	1.9	6.4	3.6
Women using contraception (%) 1986-93	39	79	15	55

Source: Haq *ul* 1997.

### **Defining Unmet Need**

Traditionally, the concept of unmet need originates from the field of family planning where it has been extensively used to measure the proportion of women/couples who want to limit and/or space their births but are not using any form of contraception. Because family planning is now seen as an integral part of reproductive and sexual health, this concept of unmet need must be redefined. In a recent essay, Ruth Dixon-Mueller and Adrienne Germain define a broader scope of unmet need. They argue that the concept of unmet need should include:

- recognizing the need among non-users at risk of unwanted pregnancy for any method of contraception;
- the need among some users for a more effective, satisfactory, or safer method;

- the need among both users and non-users for treatment of contraceptive failure (or non-use) through safe and accessible abortion services; and
- the need for related reproductive health services such as the prevention and treatment of reproductive tract infections (RTIs) (Germain and Dixon-Mueller 1992 : 33-335).

The concept of unmet need is likely to evolve and be further refined as programs make a paradigm shift and begin to implement comprehensive sexual and reproductive health services.

### The Paradigm Shift

In order to operationalize reproductive health programs, a change in focus from a population control approach of reducing numbers to a reproductive health approach of addressing the needs of clients is necessary. Implementing reproductive health services within national programs in South Asian countries may require an ideological shift. In India, for example, it would necessitate a change in the culture of the program which has focused in the past on achieving targets to one that will now aim at providing a range of good quality services. The implication is that reproductive health programs should be responsible for reducing the burden of unplanned and unwanted child bearing and related morbidity and mortality (Jain and Bruce 1994 : 192-211). Achieving the demographic goal of reducing the rate of population growth requires broader social and economic macro-level policies such as policies to improve education and enhance

employment opportunities for women.

### Reproductive Rights and Sexual Health

While reproductive health needs are beginning to be defined, those related to reproductive rights have barely begun to be even articulated in South Asia and are, therefore, largely unmet. The proponents of the reproductive health framework believe that reproductive health is inextricably linked to the subject of reproductive rights and freedom, and to women's status and empowerment. Thus, the reproductive health approach extends beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during the various stages of the life-cycle. In addressing the needs of women and men, such an approach places an emphasis on developing programs that enable clients to:

- make informed reproductive choices and exercise their right to choose;
- receive education and counseling services for responsible and healthy sexuality;
- obtain services for the prevention of unwanted pregnancy, safe abortion, maternity care and child survival, and for the prevention and management of reproductive morbidity including gynecological problems, reproductive tract infections (RTIs), sexually transmitted infections (STIs) and HIV/AIDS.

Thus, reproductive and sexual health programs are concerned with a set of specific health problems, identifiable

Table 2 Selected Health Indicators for Countries in South Asia and Developing Countries

	India	Pakistan	Bangladesh	Nepal	Sri Lanka	South Asia Weighted Average	Developing Countries
Population with access to health services (%) 1993	85	55	45	N/A	93	78	80
Population per doctor							
• 1976	3,140	3,780	11,350	38,650	6,230	4,665	N/A
• 1988-91	2,439	2,000	12,500	16,667	7,143	3,697	5,767
Population per nurse							
• 1976	6,320	10,040	53,700	52,770	2,240	12,061	N/A
• 1988-91	3,333	3,448	20,000	33,333	1,754	5,465	4,715
Maternal mortality rate per 100,000 live births 1993	570	340	850	1,500	140	583	384

Source: Haq ul. 1997.

clusters of client groups, and distinctive goals and strategies.

### Unmet Needs in South Asia

This evolving paradigm is being put to its most critical test in South Asia, which is fast emerging as the poorest, the most illiterate, the most malnourished, the least gender-sensitive — indeed, the most deprived region in the world (Haq ul 1997) (Tables 1 & 2). A recent assessment of human development in South Asia, including India, Pakistan, Bangladesh, Nepal, Sri Lanka, Bhutan, and Maldives, showed that while these seven countries share many common characteristics, their performance in raising the level of human development is variable. There has been some progress in the field of health in South Asia. Infant mortality has been cut in half in the last three decades and life expectancy has increased by 17 years, from 44 in 1960 to 61 in 1993. But, there are serious gaps in the field of education. More than one-half of the population in South Asia is still illiterate.

Human deprivation is especially grim for women. Two-thirds of adult women in the region are illiterate and maternal mortality is among the highest in the world. A comparison of South Asia's performance with that of East Asia is revealing. Starting with similar income levels three decades ago, East Asia is now way ahead of South Asia in its social and health indicators. It is clear that South Asia has failed to provide adequate coverage of basic social services to its 1.2 billion people (Haq ul 1997).

Although a sub-continent, there are significant differentials among the countries of South Asia (Tables 3 & 4). At one end of the spectrum is Sri Lanka — its human development and health indicators are among the highest in the world, often surpassing those of many developed countries. Its adult literacy, for example, is 90 percent. Population growth rate is 1.5 percent, compared to an average of 2.3 percent for South Asia. Its life expectancy at 72 is 11 years longer than the South Asian average of 61 years. Infant mortality in Sri Lanka is 15 per 1000 live births compared to 91 in Bangladesh, 95 in Pakistan, and 79 in India. Basic health facilities are available to 93 percent of Sri Lanka's population (Haq ul 1997). In contrast, other South Asian countries, such as Pakistan, India, and Bangladesh depict gloomy socio-demographic and health profiles indicating a huge unmet need in these countries. The Reproductive Risk Index

designed by Population Action International ranks India and Sri Lanka in the moderate risk category, and Bangladesh, Nepal, and Pakistan in the high risk group (Population Action International 1995).

**Table 3** Selected Social & Health Indicators for Countries in South Asia

	India	Pakis- tan	Bangla- desh	Nepal	Sri Lanka
Population in absolute poverty (%) 1993					
• number (millions)	416	36	60	8.4	6.0
• as % of total population	46	28	52	40.0	31.0
Population without access to health services 1993					
• number (millions)	135	60	63	N/A	1.3
• as % of total population	15	45	55	N/A	7.0
Illiterate female adults 1993					
• number (millions)	183	28	26	5.4	0.8
• as % of total adult female population	64	77	75	87.0	14.0
Malnourished children under 5, 1994					
• number (millions)	62	10	11	2.0	0.8
• as % of total under-5 population	53	40	67	49.0	38.0
Under-five mortality rate 1994 (per 1,000 live births)	119	137	117	118	19

Source: Haq ul 1997.

### Addressing Unmet Needs

Addressing unmet needs implies designing strategies to target neglected client groups such as women, men and adolescents as well as implementing services to meet their priority reproductive and sexual health needs throughout the life-cycle.

#### *Unmet Needs of Women : Users' Perspectives on Improving Quality of Care*

Past programs have focused primarily on addressing family planning needs. Future programs must also address other reproductive health needs of women. Family planning efforts should be focused on: (1) reaching the unreached especially where access remains a problem as in Nepal, Pakistan, and Myanmar and serving unserved areas of other countries; (2) expanding contraceptive choice, particularly in countries like India, where the program essentially relies on a single method; and (3) improving the quality of services, which is

Table 4 Profile of Human Development for Countries in South Asia

Country	Life expectancy at birth (years) 1994	Population with access to			Daily calorie supply per capital 1992	Adult literacy rate (%) 1994
		Health services (%) 1990-95	Safe water (%) 1990-96	Sanitation (%) 1990-96		
Thailand	69.5	90	89	96	2,443	93.5
Philippines	67.0	71	86	77	2,258	94.4
Indonesia	63.5	93	62	51	2,755	83.2
Vietnam	66.0	90	43	22	2,250	93.0
Myanmar	58.4	60	60	43	2,598	82.7
India	61.3	85	81	29	2,395	51.2
Pakistan	62.3	55	74	47	2,316	37.1
Bangladesh	56.4	45	97	48	2,019	37.3

Source: Haq ul 1997.

an unmet need of all countries in the region.

If reproductive health programs are designed to address clients' needs, the quality of services must be improved, particularly as perceived by clients. There is a need to focus on women since they constitute the major client group or users of these programs and also have the greatest problem of access, both physical and social, to health services (Pachauri 1994).

There are ample data worldwide showing a high burden of reproductive morbidity among women in developing countries. According to the World Bank, about one-third of the total disease burden in developing countries among women in the age group of 15 to 44 years is linked to health problems related to pregnancy, childbirth, abortion, human immuno-deficiency virus (HIV), and RTIs (World Bank 1993). Available data for South Asia show that women have a huge unmet need for services related to these conditions. Socio-economic and biological determinants operate synergistically throughout the lives of poor women in South Asia to undermine their health, resulting in high levels of morbidity and mortality (Gittlesohn et al. 1994; Akhtar, Rahman and Ahmed 1996). However, among diseases for which cost-effective interventions exist, reproductive health problems account for the majority of the disease burden in women of this age group. There is, therefore, an urgent need to design and implement cost-effective programs to address women's reproductive health needs. Women-centered, gender-sensitive services must be organized and implemented (Pachauri 1995).

#### *Unmet Needs of Men: Men as Partners*

Since gender inequalities favor men in South Asian countries and sexual and reproductive health decisions are largely made by men, there is a growing realization that unless men are reached, program efforts will have limited impact. Research on sexuality, especially in the field of HIV/AIDS, has highlighted the inadequacy of strategies that target only women. Because of the prevailing gender-power equation, women are not only specially vulnerable, but are also unable to negotiate changes in sexual behavior. Research on sexual negotiation has dramatically underscored the need for involving men in programs that aim at bringing about changes in sexual behavior for the prevention of infection. However, such behavioral change is relevant not only for the prevention of infection but also for addressing other reproductive and sexual health problems. Reproductive and sexual health needs of men have not been addressed by past programs that have mainly targeted women. Men too have unmet needs as illustrated by recent work in India (Khan, Khan and Mukherjee 1997:18-30) and Bangladesh (Hawk 1997). Therefore, the involvement of men as partners is essential (Pachauri 1996).

#### *Unmet Needs of Adolescents: A Neglected Group*

Adolescents are another neglected client group. Adolescents have been by-passed by all programs and consequently their needs have neither been assessed nor addressed. Health services for the adolescent girl have special significance in South Asian countries where there is a strong son preference. Such services would not only affect the health of the adolescent girl but would also have long-term inter-

generational effects by reducing the risk of low birth weight and minimizing subsequent child mortality risks. So far, neither services nor research have focused on the adolescent's health and information needs. Youth 10-24 years of age represent about a third of the population in the countries of South Asia (Population Reference Bureau 1996). Therefore, the consequences of this neglect takes on enormous proportions, particularly as adolescents are exposed to the rising threat of HIV and STIs (Pachauri 1995).

### **Reducing the Burden of Reproductive and Sexual Health Morbidity**

Data on the magnitude of reproductive and sexual health morbidity in South Asia are sparse. Research is urgently needed to systematically assess the extent of reproductive and sexual health problems in the countries of the region so that program priorities can be delineated. The following section provides an assessment of the magnitude of priority problems which must be urgently addressed.

#### *Maternal Mortality and Morbidity: A Neglected Tragedy*

The magnitude of women's reproductive health problems is reflected in the number of deaths related to pregnancy and childbirth, the most direct indicator of reproductive health care. Worldwide, there are half a million deaths of women each year related to pregnancy and all but 6,000 of these occur in the developing world. Maternal mortality is notoriously difficult to measure accurately and so only estimates are available. India's maternal mortality ratio, 400-500 per 100,000 live births, is fifty times higher than that of many developed countries and six times higher than that of Sri Lanka (Ascadi and Johnson-Ascadi 1990). The maternal mortality ratio is estimated at 450 in Bangladesh (Ascadi and Johnson-Ascadi 1990) and at 1,500 in Nepal per 100,000 live births (United Nations 1995).

Mortality statistics, however, tell us only a part of the story. For every woman who dies, many more suffer serious illness. Community-based data on maternal morbidity are scarce. In recent studies, for every maternal death there were 643 morbidities in Bangladesh and 541 in India (Fortney and Jason (eds)1996). In Bangladesh and India, 80 and 58 percent women respectively, reported at least one morbidity during pregnancy and the puerperium; 24 and 2 percent respectively, reported five or more morbidities. A life-threatening morbidity was reported by 5 percent of Indian

women and 32 percent of Bangladeshi women. Life-threatening and serious morbidities were reported by 46 percent of Indian and 65 percent Bangladeshi women. For every woman who died from pregnancy-related causes, 65 percent women in Bangladesh and 25 percent in India suffered from chronic morbidity (Fortney and Jason (eds) 1996).

These data on maternal mortality and morbidity underscore the high level of unmet need for maternity care among women in South Asian countries. By some estimates, better care during labor and delivery could prevent 50-80 percent of maternal deaths (Rodriguez et al. 1985; Walker et al. 1986 : 486-488). But, the vast majority of births in India, Bangladesh, and Pakistan take place at home and, are handled mostly by untrained births attendants. As recently as 1992-1993, no more than 16 percent of all rural births in India were conducted in institutions and as many as two-thirds were delivered by traditional birth attendants (International Institute of Population Studies 1994). In Sri Lanka, however, trained personnel attend 94 percent of the births (United Nations 1995).

Malnutrition is an underlying problem that seriously affects the health of adolescent girls and adult women and has its roots in early childhood. About 85 percent women in South Asia are anemic. The association between anemia and low birth weight, prematurity, perinatal mortality and maternal mortality has been extensively documented in South Asian countries.

An area that has not been explored relates to violence and injuries which accounted for 14 percent of maternal deaths in a study in Bangladesh (Rahman, Whittaker and Hossain 1991). Recent research shows that gender violence is pervasive in South Asian countries (Sidney, Hashemi and Riley 1997; Sood (ed) 1990; Deraniyagala 1990). This problem, however, remains invisible because of the silence that shrouds it. It is a problem that is denied by society.

#### *Unsafe Abortion: A Pervasive Problem*

Unsafe induced abortion is the greatest single cause of mortality, and at the same time, the most preventable one. Of all the major causes of maternal deaths, those that lead to abortion deaths are the best understood. Women do not need to die or suffer medical consequences from abortions

because abortions do not necessarily kill; it is carelessly performed abortions which kill (Maine 1991). Abortion is illegal in most South Asian countries. In India abortion was legalized over twenty years ago, but is still a neglected problem. Access to safe abortion services for poor women, especially in rural areas, remains problematic in India.

The conceptual link between family planning and abortion is fundamental. Effective contraception is an important means of preventing unwanted pregnancy thus pre-empting the need for abortion. In the absence of safe contraceptive backup, however, women will continue to be forced to employ unsafe means for terminating unwanted pregnancies with attendant high maternal mortality and morbidity.

Data on abortion are unreliable and difficult to obtain. According to official estimates 1.5 million abortions occur in South Asia each year. The estimated abortion rates per 1000 women of reproductive age are 3.4 in Bangladesh, 3.0 in India, 4.1 in Nepal, and 5.4 in Sri Lanka (International Planned Parenthood Federation South Asia Region 1994). These figures are likely to be significant underestimates because abortion is illegal and/or severely restricted in all South Asian countries except India. Therefore, the majority of abortions in the region are clandestine; are usually performed under unsafe conditions; and are not reported (Kapoor 1997).

#### *Reproductive Tract Infections: A Silent Epidemic*

Since community-based research on women's reproductive illnesses, including RTIs and STIs, was neglected in the past, these problems remained invisible (Bang and Bang 1991: 27-30). Rani Bang's landmark study in a rural, tribal area of Maharashtra, India, indicating that 92 percent of the women suffered from one or more gynecological problems and that the majority had never sought any treatment, created quite a stir nationally and internationally. This study not only depicted the magnitude of the problem of gynecological morbidity in poor women, but also brought into focus the neglect associated with these problems (Bang et al. 1989 :85-88). It highlighted the need for further research to assess levels of morbidity among poor women.

A recent review of nine community-based studies of gynecological morbidity in India showed a considerable burden of RTIs/STIs ((Koenig et al. 1996). In Maharashtra,

the prevalence of infections including vaginitis, cervicitis, and pelvic inflammatory disease (PID) was 46 percent (Bang et al. 1989 :85-88). In four community-based studies of gynecological morbidity recently conducted in four different sites in India (rural West Bengal and Gujarat, and urban Baroda and Bombay), the prevalence of clinically diagnosed RTIs ranged from 19 to 71 percent (Baroda Citizens Council). In a similar study conducted in rural Karnataka, over 70 percent of women had clinical or laboratory evidence of RTIs (Bhatia et al. 1997 : 95-103). These studies leave little doubt that prevalence of RTIs in India is unacceptably high and that gynecological morbidity constitutes a major public health problem among poor women.

Research in India shows that poor women carry a heavy burden of reproductive morbidity; a significant component of such morbidity is unrelated to pregnancy and is due to RTIs, many of which are sexually transmitted; these reproductive problems are invisible because of socio-cultural reasons and are unattended because women do not have access to health care for these illnesses (Pachauri 1994).

Studies in Bangladesh also show a significant burden of reproductive morbidity. In a survey of a rural community, where the magnitude and nature of morbidity due to RTIs among users and non-users of contraceptives was assessed, 22 percent of the 2,929 women surveyed reported symptoms of infection. Of the 472 symptomatic women examined, 68 percent had clinical or laboratory evidence of infection (Wasserheit et al. 1989 : 69-79).

Thus, there is growing evidence that the burden of reproductive morbidity is unacceptably high among poor women in South Asia. This represents an important unmet need because these RTIs are frequently asymptomatic in women and are not recognized and treated. Certain contraceptive methods increase the risks of RTIs. For example, oral contraceptives predispose women to candidiasis and chlamydia infection (Wasserheit et al. 1989 : 69-79). These linkages between RTIs and contraception further complicate the problem, adding yet another dimension to the already complex challenge of addressing these problems.

Poor women are also at increased risk of RTIs because of the unhygienic management of menstruation. Childbirth and

abortion exacerbate infections of the lower reproductive tract and facilitate their spread to the upper tract. Untreated lower tract infections are likely to progress to pelvic inflammatory disease which has serious sequelae including infertility, ectopic pregnancy, chronic pain, and recurrent infection. The problem of infertility is particularly serious and can be devastating for women in South Asia where child bearing is highly valued. RTIs and STIs, poor obstetric and gynecological practices, illegal abortions and postpartum and postabortion infections are all preventable causes of infertility (Pachauri 1994). In addition, RTIs effect fetal wastage, low birth weight and congenital infection, and thereby, impact on pregnancy outcome, child health and survival. The treatment of these infections is, therefore, a cost-effective approach to reduce perinatal and neonatal mortality. Child survival programs currently underway in South Asia are not designed to address these problems (Pachauri 1994).

#### *Cancers of the Reproductive System: An Unaddressed Problem*

So far, cancers of the reproductive tract have received little attention even though these increasingly contribute to reproductive morbidity in South Asia. Cancer is one of the three leading causes of adult female mortality in both developed and developing countries. While breast cancer is the most frequently occurring cancer among women in the industrialized countries, cervical cancer is the most common malignancy in developing countries where it accounts for 20 to 50 percent of all cancers and 80 to 85 percent of all malignancies of the female genital tract (Belsey and Royston 1987). In India, the incidence of cervical cancer ranges from 15.4 to 46.5 per 100,000 women (Indian Council of Medical Research 1990)

There is an established association between RTIs and cervical cancer (Mishra and Sinha 1990 : 21; Indian Council of Medical Research 1990; Murthy, Sehgal and Satyanarayana 1990 : 732-736). Early onset of sexual activity and multiple sexual partners increase the risk of cervical cancer (Menon et al. 1988: 2-4). The high incidence of cervicitis that is not due to conventional STI pathogens, has been postulated as a possible risk factor for cervical cancer among Indian women (Luthra et al. 1992).

Cervical screening is an important means for preventing cancer but at present only limited screening facilities are available to women in South Asia. For example, while 15

percent of the world's cervical cancer cases exist in India, screening facilities are available only to a small minority of urban women.

#### *HIV/AIDS: A Problem Denied*

By the turn of the century, Asia is expected to become the epicenter of the global HIV/AIDS pandemic. Denial of the problem in South Asia continues to impede action. This represents a huge unmet need for South Asia.

After the first AIDS case was reported in India in May 1986, some 6,154 cases have been reported (National AIDS Control Organization 1998). These reported figures are believed to be a gross underestimate. Over the years, there has been a steep rise in the reported seropositivity rate – from 2.5 per 1000 in 1986 to 20 per 1000 in 1998 (National AIDS Control Organization 1997). The prevalence of HIV infection has been on the rise in practically all states and all population groups in India. The increase is observed irrespective of when the infection reached a state. For example, no HIV infection was reported in Orissa till the end of 1992 but within a year of its detection, prevalence increased about three-fold (National AIDS Control Organization 1994).

The north-eastern region of India is experiencing a major HIV/AIDS epidemic. In this region, infection is spread predominantly by injecting drug users. The state of Manipur which borders Myanmar, accounts for the highest number of cases in this region. After its initial detection in 1989, the prevalence of HIV among intravenous drug users in Manipur increased sharply. It was 64 percent by 1993 (Sarkar et al. 1993 : 23-28). Manipur State borders the 'Golden Triangle' of Myanmar, Laos and Thailand and is on the drug trading route. There is an explosive HIV/AIDS epidemic among drug users in Myanmar where over 60 percent of the world's opiates are produced.

The dominant mode of HIV transmission is heterosexual and this accounts for about two-thirds of the infections in South Asia. Therefore, addressing unmet need in the area of sexuality is a priority because changing sexual behaviors to promote safer sexual practices lies at the heart of HIV/AIDS prevention (Pachauri 1997). Information on HIV/AIDS and STIs in Pakistan, Nepal, and Bangladesh is inadequate and scanty. The magnitude of the problem is, therefore, not known. This implies that there is a serious unacknowledged and unmet need in these countries.

### **Integrating Services: A Bureaucratic Challenge**

There is a growing realization that horizontal integration of services must be achieved if reproductive and sexual health and rights are to be universally realized. There must be a convergence of services at the user's level as the user or client has multiple reproductive health needs and often the same providers deliver services that are administered through multiple vertical programs. Vertical programs that originate from different government departments and are funded by multiple donors, each with its own agenda, can result in a multiplicity and fragmentation of services which can be wasteful and inefficient.

Thus far, most reproductive health programs are provided through vertical systems. Services for promoting family planning, improving child survival, and preventing HIV/AIDS are particular examples. It would be counterproductive to have reproductive health as yet another vertical program. In fact, the reproductive health approach provides an opportunity for integrating services. A critical mass of resources could also achieve greater cost-effectiveness.

In South Asian countries, governments have implemented family planning programs for the past three to four decades. Child survival programs have been implemented since the 1980s. Services for promoting safe motherhood have been put in place more recently. Prevention of HIV/AIDS and STIs are also more recent initiatives. The challenge is to strengthen all these services by expanding their reach, improving their quality and effectively integrating additional reproductive health services within ongoing programs.

### **Gender Disparity: A Fundamental Problem**

Women bear the greatest burden of human deprivation in South Asia. The Gender-related Development Index (GDI), which adjusts the measure of average human development to take account of gender disparities, shows a value of only 0.41 for South Asia, which is 25 percent lower than the average for developing countries and less than half that of the industrial world. However, access to political, economic, and social opportunities, that is reflected by the Gender Empowerment Measure (GEM), starkly indicates deprivation among South Asian women. South Asia's GEM index of 0.23, is the lowest among all regions of the world, including Sub-Saharan Africa (Haq ul 1997).

For the most part, the neglect of women is related to low status and lack of autonomy. There is an overwhelming son preference in South Asian societies. South Asia is the only region in the world where men outnumber women. While Sri Lanka and Maldives have nearly equal male-female populations, the ratio of females for every 100 males is 96 in Nepal, 93 in Pakistan, 94 in India (Haq ul 1997). Some 74 million women are simply missing in South Asia! Women's voices have yet to be heard by the vanguards of society.

While the neglect of women is a widespread phenomenon throughout South Asia, there are some important differences among the countries of the region. Sri Lanka has performed fairly well in investing in and providing opportunities to women. In Sri Lanka, female literacy is 86 percent, female life expectancy is 106 percent of male life expectancy, and the female economic activity rate is 36 percent. Pakistan, on the other hand, ranks lowest in the region in most gender-related human development indicators. Its female literacy rate is only 23 percent; female school enrollment is 16 percent; and female participation in economic activities is only 16 percent (Haq ul 1997).

### **Concluding Comments**

Even though reproductive health rhetoric is now used by many, there are major information gaps at all levels ranging from a lack of understanding of the reproductive health and rights concepts to questions about what short-term and long-term strategies are needed at the policy and program levels to implement services. This lack of information presents a major deterrent to implementing programs to address unmet reproductive and sexual health needs in South Asia. Strong advocacy is needed to translate the rhetoric into reality. A range of different constituencies, including governments, donors, NGOs, activists, feminists, and researchers, must be informed and empowered to catalyze a process of networking with a growing number of stakeholders so that the ideology and the ethos embodied in the reproductive health concept is effectively internalized and programs responsive to clients' needs are designed and implemented (Pachauri 1995).

The magnitude of unmet reproductive and sexual health needs in South Asia is daunting. The problems in this deprived region are many. However, a changing policy environment presents an opportunity to make a difference.

Several countries in the region are making a paradigm shift and are redesigning their national programs to operationalize the ICPD Plan of Action. Reproductive and sexual health programs are now on the agenda of South Asia. India launched a major national Reproductive and Child Health program in October, 1997. Bangladesh is in the process of designing a program. Discussions are underway in other countries of the region to define reproductive health agendas and to redesign programs responsive to local needs.

Translating reproductive rhetoric into reality in South Asia presents a challenge that will require joint action by governments, donors, NGOs, the private sector and the larger civil society. Concerted efforts must be made to provide an enabling environment and to promote partnerships so that unmet reproductive and sexual health needs of the peoples of South Asia can be addressed by the involvement and participation of all.

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