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ALLAMA IQBAL OPEN UNIVERSITY, ISLAMABAD

Course: Women and Health (877) • Level: MSc

Department of Gender & Women Studies

Semester: Autumn 2026

Assignment No. 2 (Units 6–9)

Total Marks: 100 • Pass Marks: 40

SOLVED ASSIGNMENT GUIDE

(For Study & Reference)

Note: This guide is prepared for study and reference purposes only. Students are advised to read the relevant units of the course book, understand the concepts, and write the assignment in their own words. Copying this guide word for word is discouraged.

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Question 1: Forms of Wife Beating in the Global Context (20 Marks)

Describe the forms of wife beating in the global context.

Introduction

Wife beating — physical violence against a woman by her husband or intimate partner — is the most common form of violence against women in the world. The World Health Organization estimates that nearly one in three women aged 15–49 who have ever been in a relationship have experienced physical and/or sexual violence by an intimate partner in their lifetime, and wife beating in its various forms is the core of that figure. Although the phrase sounds simple, the practice is not: across countries and cultures it takes many forms, follows recognisable patterns, is justified by recurring excuses, and produces a consistent profile of injury and illness. This answer describes the forms of wife beating in the global context — direct physical assaults graded by severity, violence during pregnancy, violence with weapons and household objects,

and the closely connected forms of sexual, psychological and economic abuse with which beating is almost always combined — and then examines its global patterns, cultural justifications, health consequences and the international response.

Two cautions frame the discussion. First, wife beating is not confined to any one region, religion, class or level of development: prevalence varies greatly — lifetime rates in WHO multi-country research ranged from about 15 per cent to over 70 per cent across study sites — but no country studied was free of it. Secondly, official figures everywhere understate reality, because beating is hidden by shame, fear, economic dependence and the widespread treatment of the matter as a private family affair. What statistics describe is therefore the visible portion of a much larger global pattern.

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Direct Physical Forms: From Slapping to Life-Threatening Assault

Surveys and health research conventionally divide physical partner violence into moderate and severe forms, a distinction first systematised in instruments such as the Conflict Tactics Scales and used in the WHO multi-country study and the Demographic and Health Surveys (DHS) domestic violence module. Moderate forms include slapping, pushing or shoving, throwing objects at the woman, twisting her arm and pulling her hair. Severe forms include punching with a fist, kicking, dragging along the floor, beating repeatedly, choking or strangling, burning deliberately, and attacking or threatening with a weapon such as a knife, stick or firearm. In practice these are rarely single incidents: the defining feature of wife beating in most settings is repetition — episodes recurring over years, often escalating in severity, and interspersed with apologies and calm, in the cycle of violence described by Lenore Walker (tension building, acute battering, contrition and calm, then tension again).

The objects and settings are remarkably consistent across cultures because they are drawn from the household itself: hands and feet, belts, shoes, sticks, kitchen implements, kerosene and boiling water or oil in South Asian kitchens, agricultural tools in rural areas, and firearms where they are common in the home, notably in parts of the United States and conflict-affected regions. Certain named practices belong to particular cultural settings but illustrate the global phenomenon: dowry-related beatings and bride-burning in parts of South Asia, where violence is used to extract further payments from a wife's family; "honour"-linked beatings in parts of the Middle East and South Asia, where a wife's perceived disobedience or suspected infidelity is treated as family dishonour; and alcohol-fuelled weekend beatings documented from Latin America to Southern Africa, where drinking does not cause the violence but is its most common immediate trigger and excuse.

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Table 1: Forms of wife beating recorded in global research

Category	Typical acts	Common settings / notes
Moderate physical violence	Slapping, pushing, shoving, throwing objects, arm-twisting, hair-pulling	Most widely reported form worldwide; often minimised as "minor"
Severe physical violence	Punching, kicking, dragging, repeated beating, choking, burning	Strongly associated with injury, fear and coercive control
Weapon-related violence	Attacks or threats with sticks, knives, tools, firearms	Firearms prominent in the Americas; household implements everywhere
Violence in pregnancy	Blows or kicks to the abdomen, beating during pregnancy	Recorded in almost every country studied; risks miscarriage and low birth weight
Culturally patterned forms	Dowry beatings, stove/kerosene burning, "honour" beatings	South Asia, Middle East and diaspora communities

Combined abuse	Beating with marital rape, threats, humiliation, economic deprivation	The usual real-world pattern; forms rarely occur alone

Violence During Pregnancy and Sexual Violence Within Marriage

A form of wife beating documented in almost every country is violence during pregnancy. Studies reviewed by WHO and UN agencies find that between roughly 1 per cent and over 25 per cent of pregnant women, depending on setting, report being beaten during a pregnancy, frequently with blows directed at the abdomen. The consequences are severe for two patients at once: miscarriage, premature labour, placental abruption, low birth weight and stillbirth, alongside the mother's injuries and terror. That pregnancy — a period surrounded in most cultures by protective sentiment — does not reliably protect women is one of the strongest demonstrations that wife beating is about control rather than momentary loss of temper: jealousy over the coming child, resentment of the woman's changed body or reduced capacity for work, and punishment for the sex of the expected child are among the explanations women themselves report.

Wife beating is also almost inseparable from sexual violence within marriage. Large numbers of beaten women report forced sex, sex obtained through fear of further beating, and degrading sexual acts imposed against their will. In many legal systems marital rape remains wholly or partly exempt from rape law — a legal survival of the doctrine that a wife's consent is given permanently at marriage — although reform has advanced in many countries and international human rights bodies now treat marital rape as violence to be criminalised. Reproductive coercion is a related, under-recognised form: husbands who beat their wives also commonly

forbid contraception, sabotage methods, or force pregnancy, linking physical violence directly to women's reproductive health. Any description of the forms of wife beating that stops at bruises therefore understates the phenomenon: in women's lived experience, the fist, the forced sex, the threat and the withheld money arrive as one system of domination.

Psychological, Economic and Controlling Forms That Accompany Beating

Global research using the concept of coercive control (developed by Evan Stark) shows that beating is usually one instrument in a wider regime. Psychological abuse includes constant insults and humiliation, public shaming, threats to kill or injure the woman or her children, threats to divorce her, take another wife or take the children away, destruction of her belongings, and intimidation through looks, gestures and smashing objects. Controlling behaviours include isolating her from her family and friends, monitoring her movements, forbidding her to work or study, controlling her access to health care, and insisting on knowing her whereabouts at all times. Economic abuse includes taking her earnings, refusing money for food and medicine, preventing employment, and selling her property. In the DHS and WHO instruments these behaviours are measured separately, but clinically and experientially they belong with beating: many women report that the psychological torment and the waiting for the next attack damage them more lastingly than the blows themselves.

Technology has added a contemporary global form: digital control and abuse — monitoring a wife's phone, demanding passwords, tracking her location, and threatening to publish private images. Honest description also requires noting that forms vary by life stage and household structure: young brides in extended households may be beaten not only by husbands but also by mothers-in-law, a pattern well documented in South Asia; elderly wives face beating

combined with neglect; and women with disabilities face elevated rates of partner violence with additional forms such as withholding medication, mobility aids or personal assistance.

Global Patterns, Justifications and Health Consequences

Across regions, the same triggers and justifications recur with striking consistency. In the WHO multi-country study, women and men in site after site explained beating by the wife's disobedience, answering back, neglecting children or housework, refusing sex, suspected infidelity, burning food or going out without permission. Underlying these triggers is a near-universal structure of justification: male authority in marriage is treated as natural, a husband's "discipline" of his wife is treated as legitimate correction, and outsiders — including, historically, police and courts — treat the home as private. Attitude surveys confirm how normalised this remains: in many countries, majorities of women themselves state that a husband is justified in beating his wife for at least one reason, a finding that shows how deeply the norm is internalised and why legal reform alone changes behaviour slowly. Risk is concentrated by poverty, low education, alcohol abuse, witnessing violence in childhood, and conflict and displacement, but wife beating occurs in wealthy, educated households in every country as well.

The health consequences constitute a large, consistent literature. Immediate effects are injuries — bruises, fractures, head and eye injuries, internal injuries and, at the extreme, femicide: global estimates attribute a large share of all murders of women (roughly four in ten) to intimate partners. Longer-term effects include chronic pain, gastrointestinal and gynaecological problems, sexually transmitted infections including HIV (through forced sex and inability to negotiate protection), depression, anxiety, post-traumatic stress disorder, substance use as

self-medication, and suicide — women who experience partner violence are several times more likely to attempt suicide. Children who witness beating show behavioural and emotional problems and are more likely to perpetrate or experience violence as adults, transmitting the pattern across generations.

The International Response

The global response has moved through recognisable stages: from silence, to naming wife beating as a violation of human rights (the 1993 UN Declaration on the Elimination of Violence against Women expressly includes physical, sexual and psychological violence in the family), to legal reform, services and prevention science. Most countries now have some law against domestic violence — Pakistan's provinces have enacted domestic violence legislation since 2013, alongside provisions in the Pakistan Penal Code covering hurt and related offences — and CEDAW's General Recommendations 19 and 35 oblige states to act with due diligence to prevent, investigate and punish such violence and to provide reparation and services. Effective systems combine protection orders that actually remove the danger, shelters and one-stop crisis centres, health-sector screening and first-line support following WHO clinical guidelines, and prosecution that does not depend entirely on a frightened victim's persistence.

Prevention evidence is the newest and most hopeful part of the global picture. Programmes that work with communities to change gender norms (such as SASA! in Uganda), that combine women's economic strengthening with gender training (such as IMAGE in South Africa), and that engage men and boys in redefining masculinity have measurably reduced partner violence in rigorous trials. The global lesson is consistent: wife beating in all its forms flourishes where

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male entitlement, female dependence and social silence meet, and recedes where law, services, women's economic options and community norms move together against it.

Conclusion

To conclude, wife beating in the global context is not a single act but a repertoire: moderate and severe physical assaults, weapon use, burning and dowry- and honour-patterned attacks, violence in pregnancy, marital sexual violence and reproductive coercion, all bound together by psychological torment, isolation and economic control into a system of coercive domination. It is found in every region and class, justified by a recurring script of male authority and wifely disobedience, and it produces a heavy, well-documented burden of injury, illness, mental disorder and death for women and their children. Describing its forms accurately matters because each form implies its remedy: health services that ask and respond, laws that reach inside the home, shelters and economic options that make escape possible, and prevention that changes the norms by which a raised hand against a wife is still, in much of the world, excused as discipline.

Question 2: Disability and the Models of Disability (20 Marks)

Discuss disability and different models of disability.

Introduction

More than a billion people — roughly one person in six in the world — live with significant disability, and women form the majority of them, live longer with disability, and face the combined disadvantage of sexism and disablism. Yet what "disability" means is not self-evident. Is a woman who cannot walk disabled by her spinal injury, or by the stairs, the absent ramp, the

bus she cannot board and the employer who will not hire her? The answer given to that question is a model of disability, and models are not academic decorations: they decide whether policy builds a clinic or a ramp, offers charity or rights, trains a doctor or prosecutes discrimination. This answer defines disability and its related terms, then examines in detail the main models — the charity and religious models, the medical (individual) model, the social model, the biopsychosocial model embodied in the WHO International Classification of Functioning (ICF), the human rights model of the UN Convention on the Rights of Persons with Disabilities (CRPD), and cultural and economic perspectives — comparing what each explains, what each misses, and what each implies for women with disabilities in particular.

Terminology itself carries the models. Older language — "handicapped", "crippled", "suffering from" — belongs to charity and medical thinking. Current international usage distinguishes impairment (a loss or difference in body function or structure), activity limitation, and participation restriction, and prefers "persons with disabilities", language that Pakistan's own legislation, including the ICT Rights of Persons with Disability Act 2020 and provincial laws, broadly follows.

Defining Disability: Impairment, Activity and Participation

The ICF, now the standard international framework, defines disability as an umbrella term for impairments, activity limitations and participation restrictions, arising from the interaction between a health condition and contextual factors — environmental and personal. A health condition (for example diabetes, spinal cord injury, depression or Down syndrome) may produce an impairment (amputation, paralysis, low vision, intellectual impairment). Whether that impairment becomes a serious disability depends on context: a wheelchair user in a city

with step-free transport, accessible buildings and enforced anti-discrimination law participates in work and public life in a way that a wheelchair user in a village with mud paths, no accessible transport and strong stigma cannot, although their impairments are identical. Disability is therefore best understood not as a fixed property of a person but as a relationship between a person and her environment, varying by place, class and gender.

For women, every element of that relationship is gendered. Girls with disabilities are less likely than boys with disabilities to be sent to school; women with disabilities face higher rates of violence, including from carers on whom they depend; they are often assumed to be asexual and are denied reproductive health information and services, or, at the other extreme, subjected to forced contraception or sterilisation in some settings; and poverty is both a cause of disability (through malnutrition, unsafe work, untreated illness and violence) and its consequence. Any model of disability used in women's health must be tested against this double discrimination.

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The Charity, Religious and Medical Models

The oldest frameworks are the moral and charity models. In moral or religious interpretations, disability has been read as divine punishment, a test of faith, the result of karma, or the effect of spirits — interpretations found, in different forms, in many societies including Pakistan, where disability may still be attributed to God's will, parental sin or fate. Such beliefs can produce compassion and care within families and faith communities, but they can also produce fatalism (nothing should or can be changed), concealment of disabled children — especially girls — and blame directed at mothers. The charity model, closely related, casts disabled people as objects of pity dependent on the generosity of the non-disabled: it funds homes, telethons

and donations, but on terms that require gratitude and passivity and that leave every structure of exclusion intact. Both models locate the problem, and its solution, outside ordinary rights and public policy.

The medical (or individual) model became dominant with modern medicine. It defines disability as a defect or disease within the individual, to be diagnosed, treated, cured or rehabilitated by professionals; if cure is impossible, the person is to be cared for in segregated institutions or helped to adjust. This model has delivered enormous goods: surgery, prosthetics, medication, physiotherapy and special education have transformed millions of lives, and no serious account of disability can dismiss medicine. Its critics — led historically by disabled people themselves, including the Union of the Physically Impaired Against Segregation (UPIAS) in Britain in the 1970s — identify its deeper problems: it makes professional judgement sovereign over the disabled person's own account; it measures success by normality rather than by participation or well-being; it ignores the environment entirely, so that a person may be expertly "rehabilitated" and returned to a home, school and labour market that still exclude her; and it encourages segregation in special institutions as the natural setting for disabled lives.

- Charity model: problem = the unfortunate individual; solution = pity, donations, segregated care; disabled person = passive object.
- Religious/moral model: problem = fate, sin or spiritual cause; solution = acceptance, prayer, family care; risk = blame and fatalism.
- Medical model: problem = defect in the body or mind; solution = cure, rehabilitation, professional management; risk = segregation and professional dominance.

- Social model: problem = barriers and prejudice in society; solution = accessibility, law and attitude change; disabled person = rights-holding citizen.
- Biopsychosocial (ICF): problem = interaction of condition and context; solution = combined health and environmental action.
- Human rights model (CRPD): problem = denial of equal rights and dignity; solution = legal capacity, inclusion and participation in all decisions.

The Social Model of Disability

The social model, the most influential challenge to medical thinking, draws a sharp distinction between impairment (the body's condition) and disability (the disadvantage imposed on people with impairments by a society organised without them in mind). On this account, a woman with a mobility impairment is disabled not by her legs but by stairs without ramps, information not provided in accessible formats, transport she cannot use, employers' prejudice, and laws that permit exclusion. Disability is thus a form of social oppression comparable to sexism and racism, and its remedies are political: accessibility standards, inclusive education, anti-discrimination legislation, accessible information and transport, and the organised voice of disabled people under the principle "nothing about us without us".

The social model has reshaped law and design worldwide — accessible buildings, inclusive schooling and disability discrimination acts all descend from it — and it is profoundly liberating for many disabled women because it relocates shame: the problem is the staircase, not her body. Its limitations are equally discussed in the literature. In its strong form it says little about pain, fatigue and the bodily realities of impairment that no ramp can remove; it can understate the need for medical care and personal assistance; and feminist disability scholars note that it

was developed largely around physical impairment and male experience, giving less attention to intellectual and psychosocial disability, to care relationships, and to women's specific experiences of dependence, violence and reproductive control. The mature consensus uses the social model as an indispensable corrective while supplementing it, rather than treating it as a complete account of disabled life.

The Biopsychosocial and Human Rights Models

The biopsychosocial model, formalised in the WHO ICF (2001), was designed to integrate the medical and social accounts. Functioning and disability are outcomes of interaction among a health condition, body functions and structures, activities, participation, and contextual factors both environmental (buildings, laws, attitudes, services) and personal (age, sex, education, coping). Assessment under the ICF therefore asks not only "what is the diagnosis?" but "what can she do, what does she take part in, and what in her environment helps or hinders her?" For health systems this model supports practical planning: the same intervention budget can be divided sensibly among treatment, rehabilitation, assistive technology, environmental change and anti-stigma work, and outcomes can be measured as participation — schooling attended, work done, decisions made — rather than only as clinical change.

The human rights model, embodied in the CRPD (2006), which Pakistan ratified in 2011, goes a step further. It treats persons with disabilities as subjects of rights on an equal basis with others: equal legal capacity (including the right to make one's own decisions, with support where needed, rather than having decisions substituted by guardians), liberty and freedom from exploitation and abuse, inclusive education, the right to health — including sexual and reproductive health — on the basis of free and informed consent, the right to work, and the

right to participate in public life. Where the social model explains disability, the rights model assigns duties: the state must respect, protect and fulfil these rights, and failure is not misfortune but violation. Related perspectives enrich the picture further: the Nordic relational model treats disability as a mismatch between individual and environment arising in specific situations; economic models analyse the costs of exclusion and of accommodation in labour markets; and cultural models examine how different societies define normalcy itself. Feminist disability theory weaves through all of them the insistence that gender is never a side issue.

Table 1: The main models of disability compared

Model	Where the problem lies	Main solution	View of the disabled person
Charity	Personal tragedy	Donations, segregated care	Object of pity
Religious / moral	Fate, sin, spiritual causes	Acceptance, faith, family duty	Bearer of a test or punishment
Medical	Defect within the individual	Cure, rehabilitation, expert care	Patient
Social	Barriers and prejudice in society	Accessibility, anti-discrimination law	Oppressed citizen
Biopsychosocial (ICF)	Interaction of condition and context	Combined clinical and environmental action	Person in an environment
Human rights (CRPD)	Denial of equal rights	Legal capacity, inclusion, state duties	Rights-holder

Implications for Women with Disabilities

Choosing among models has direct consequences for women's health services. Under a pure medical model, a disabled woman's clinic visit addresses only her impairment; under ICF and rights thinking, the clinic itself must change: physically accessible buildings and examination

equipment, information in sign language, Braille, easy-read and audio formats, staff trained not to address companions instead of the woman, reproductive health services offered without assumption or coercion, screening for violence that recognises carer-perpetrated abuse, and mental health support that does not mistake the effects of exclusion for symptoms of impairment. In Pakistan, where disabled women are among the poorest and least schooled citizens, where special education and rehabilitation remain concentrated in cities, and where census and survey counting of disability has historically understated its scale, the combined social-rights approach points to a clear agenda: count women with disabilities properly, make mainstream health and education physically and attitudinally accessible, enforce the employment quotas and legal protections that exist on paper, involve disabled women's organisations in design, and protect against the violence and reproductive coercion to which dependence exposes them.

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Conclusion

To conclude, disability is best defined as the disadvantage that arises when an impairment meets an unaccommodating environment, and the models of disability are competing accounts of where that disadvantage is made and how it can be unmade. The charity and religious models explain older attitudes of pity, fate and blame; the medical model contributes indispensable treatment while risking professional dominance and segregation; the social model relocates the problem to barriers and prejudice and has driven accessibility and anti-discrimination reform; the ICF biopsychosocial model integrates body and context for practical planning; and the CRPD human rights model converts the whole discussion into enforceable entitlements, with disabled people — including disabled women, doubly discriminated against

and too long spoken for — as rights-holders and participants in every decision. For the student of women's health, the lesson is operational: examine any service or policy and ask which model built it, because the model silently decides whether a disabled woman will be pitied, treated, included or heard.

Question 3: Factors Affecting Women's Health in Poor Countries (20 Marks)

Describe the factors that affect women's health in poor countries.

Introduction

Women in poor countries carry a burden of ill health that is larger, earlier and more preventable than that borne by women in rich countries — and larger, in most respects, than that borne by men in the same countries. A girl born in a low-income country faces materially higher risks of dying in childhood, of stunting and anaemia, of leaving school early, of pregnancy in adolescence, of dying in childbirth, of living with untreated chronic disease, and of spending her old age in poverty. The World Health Organization and the World Bank describe this pattern through the idea of determinants: health is produced not mainly in hospitals but in the conditions in which women are born, grow, live, work and age. This answer describes the factors that affect women's health in poor countries in organised groups — biological and life-course factors; behavioural and household factors; social and cultural factors, above all gender inequality; economic factors; environmental factors; and the health system itself — showing how they interact and compound into the observed outcomes.

A useful organising idea is that of the "three delays" and their generalisation: a poor woman's health outcome is decided long before she reaches a facility — by whether she is fed and

schooled as a girl, whether she may decide to seek care, whether she can reach and pay for it, and whether the care she finally receives is competent and respectful. Each factor below operates at one or more of those points.

Biological, Reproductive and Life-Course Factors

Biology sets the stage. Women's reproductive function exposes them to risks men do not face — pregnancy, childbirth, unsafe abortion and their complications — and in poor countries these risks are multiplied by the conditions in which reproduction occurs: early and frequent childbearing, short birth intervals, high total fertility, malnutrition and anaemia entering pregnancy, and delivery without skilled care. The great majority of the world's maternal deaths — several hundred thousand annually in recent global estimates, overwhelmingly in sub-Saharan Africa and South Asia — occur in poor countries and are mostly preventable with known interventions. Sex-specific biology also shapes non-reproductive disease: autoimmune conditions and thyroid disease are more common in women, osteoporosis follows menopause, and some cancers (cervical, breast, ovarian) are female-specific or female-dominant. Cervical cancer is emblematic: it is preventable by vaccination and screening and curable when caught early, yet it remains a leading cancer killer of women in poor countries precisely because those systems of prevention do not reach them.

The life-course dimension compounds the biological one. Under-nutrition of girls produces stunted mothers whose pelvises and reserves make childbirth riskier; anaemia acquired in adolescence persists into pregnancy; infections untreated in youth become infertility, chronic pelvic pain or ectopic pregnancy; and the cumulative wear of heavy labour, repeated pregnancy and poor diet presents in middle age as hypertension, diabetes and musculoskeletal disease at

earlier ages than in rich countries. Health in poor countries must therefore be read as an accumulation: each stage inherits the deficits of the stages before it.

Social, Cultural and Gender Factors

The strongest single family of determinants in poor countries is gender inequality itself. Son preference leads families to feed, immunise and seek care for boys more readily than girls — excess female child mortality in parts of South Asia is its statistical trace — and allocates food within households in ways that leave women and girls eating last and least. Low female education is devastatingly efficient as a health risk: it is associated with earlier marriage, higher fertility, lower use of contraception and skilled care, poorer child nutrition and higher child mortality, while each additional year of a mother's schooling measurably improves her children's survival. Early marriage — still common across poor countries, with roughly one in five young women worldwide married in childhood — truncates schooling, begins childbearing before physical maturity, and places a girl under the authority of a husband and in-laws with little power to negotiate sex, contraception or care-seeking.

Restricted mobility and decision-making operate daily: many women require permission, accompaniment and money controlled by others before they can visit a facility, converting treatable conditions into emergencies. Gender-based violence — intimate partner violence, sexual violence, harmful practices such as female genital mutilation in parts of Africa and child marriage itself — directly injures health and, through fear and control, restricts access to care. Women's work is a further social determinant: the double burden of income work plus unpaid care and domestic labour, including hours spent fetching water and fuel, produces exhaustion, injury and exposure (notably to household air pollution) while leaving no time for rest or care of

their own health. Finally, information poverty — low literacy, exclusion from media and digital channels, and myths unchallenged by schooling — leaves women dependent on rumour for the most intimate decisions of their lives.

Table 1: Major determinants of women's health in poor countries

Group of factors	Examples	Typical health effects
Biological / life-course	Early, frequent pregnancy; anaemia; stunting; menopause without care	Maternal death, obstetric complications, chronic disease, osteoporosis
Social / gender	Son preference, low education, early marriage, restricted mobility, violence	Under-nutrition, delayed care, injuries, HIV risk, mental illness
Economic	Poverty, food insecurity, informal work, user fees, no insurance	Untreated illness, catastrophic health spending, maternal and child under-nutrition
Environmental	Unsafe water, poor sanitation, cooking smoke, unsafe housing and work	Diarrhoeal disease, respiratory illness, burns, occupational injury
Health system	Distance, staff shortages, stock-outs, disrespectful care, no female providers	Deaths from treatable causes, unmet need for contraception, late cancer diagnosis
Political / structural	Weak public spending, conflict, displacement, discriminatory laws	Collapsed services, epidemic vulnerability, refugee women's health crises

Economic and Environmental Factors

Poverty is the medium in which all the other factors swim. Poor households cannot reliably buy adequate food, and women — who frequently prioritise children and husbands — absorb the deficit in their own bodies: underweight, micronutrient deficiency and anaemia affect a large share of women of reproductive age in low-income countries (globally, about one in three

women of reproductive age is anaemic, with the highest rates in poor countries). Illness itself then deepens poverty, because care is commonly paid out of pocket: transport, medicines bought privately when public stocks fail, informal payments and lost wages can push a family below the poverty line, and women's conditions — fistula repair, cancer treatment, mental health care — are often the ones deferred when money is short. Women's concentration in informal, unprotected work (agriculture, domestic work, home-based piece work) means low and irregular income, no maternity protection, no insurance and occupational exposures without regulation.

The physical environment of poverty is itself pathogenic. Unsafe water and inadequate sanitation cause diarrhoeal disease and environmental enteropathy, and the labour of water and fuel collection falls on women and girls. Household air pollution from solid fuels burned in poorly ventilated kitchens — used by billions of people in poor countries — is a major cause of chronic respiratory disease, eye disease and adverse pregnancy outcomes in women, who receive the highest exposures precisely because cooking is their assigned work. Unsafe housing, lack of menstrual hygiene facilities at school and work, dangerous roads and transport, and climate change — heat, flood, drought and food-price shocks, whose burdens of adaptation fall heavily on women as food producers and water collectors — complete an environmental account in which women's assigned roles systematically maximise their exposure.

The Health System as a Factor

Health systems in poor countries often convert manageable problems into deaths through absence, distance and quality failure. Facilities are concentrated in cities while most poor women live rurally; staff — especially female doctors, midwives and specialists — are scarce

and unevenly distributed; essential medicines and blood for transfusion stock out; equipment goes unmaintained; and referral transport is left to families. Where services exist, quality and respect determine whether women return: examinations without privacy, scolding for late arrival or for home practices, informal charges and absence of a female provider all deter future use, a deterrent effect documented as strongly as distance in many studies. Services are also vertically skewed: a poor woman may be reached by immunisation and family planning campaigns yet find no care for hypertension, diabetes, depression, prolapse or cancer symptoms, because non-communicable disease and mental health services for adults remain the weakest part of most low-income systems even as those diseases rise.

Financing structures entrench the problem. Low public health expenditure (many poor countries spend a small fraction of what high-income countries spend per person), dependence on out-of-pocket payment, and donor funding tied to selected diseases leave women's comprehensive care chronically underfunded. Governance failures — absenteeism, leakage, weak regulation of a large unqualified private sector to which poor women turn first — mean that even allocated resources do not reliably become care. War, political instability and epidemic shocks then periodically destroy what exists: in conflict and displacement, maternal care, contraception and protection collapse together, and women's health indicators deteriorate fastest, a theme taken up again in the discussion of women in war zones in this assignment.

How the Factors Interact

The decisive point is that these factors do not act additively but interactively. Consider one typical pathway: a girl in a poor rural family is underfed relative to her brother, leaves school at

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puberty, marries at 17, becomes pregnant while anaemic and stunted, works through pregnancy, cannot decide alone to seek care, reaches a facility late after transport is arranged and money borrowed, and there finds no blood available for her haemorrhage. Her death certificate will record a medical cause; her biography records the true one. Public health calls this the social patterning of risk, and it explains why purely clinical investment in poor countries yields disappointing returns unless paired with girls' education, poverty reduction, women's legal and economic empowerment, water, sanitation and clean energy, and health-system reform toward universal, respectful, free-at-point-of-use primary care. It also explains the optimism of the evidence: because the determinants are social, they are changeable, and countries that have invested across them — Sri Lanka and Kerala historically, Rwanda and Ethiopia more recently in maternal care — have achieved women's health outcomes far better than their income alone would predict.

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Conclusion

To conclude, women's health in poor countries is affected by an interlocking set of factors: reproductive biology lived under conditions of under-nutrition and early, frequent childbearing; gender inequality expressed in son preference, low education, early marriage, restricted mobility and violence; poverty and unprotected work; a hazardous domestic and natural environment; and weak, distant, under-financed health systems that women experience as costly and often disrespectful. No single factor explains the pattern, and no single-sector policy can repair it. The policy conclusion drawn throughout this course follows directly: improve women's health by acting simultaneously on the clinic and on the conditions — feed and educate girls, delay marriage, give women income, property and voice, provide water,

sanitation and clean fuel, and build primary health care that is near, free, stocked and respectful. Where that combination has been tried, the supposedly inevitable ill health of poor women has repeatedly been shown to be nothing of the kind.

Question 4: Strategies for Improving Aid for Women's Health (20 Marks)

Enlist in detail the strategies for improving the aid for health for women.

Introduction

International aid — the grants, concessional loans, technical assistance, commodities and debt relief provided by donor governments, multilateral agencies, global health initiatives and international non-governmental organisations — finances a substantial share of women's health care in poor countries: family planning commodities, maternal health programmes, HIV services, immunisation, nutrition and, increasingly, cervical cancer prevention. Yet decades of experience show that aid can fail women even when money is spent: it arrives in fragmented projects, follows donor fashions, bypasses or overwhelms national systems, funds some diseases lavishly and others not at all, and too often measures success in workshops held and commodities shipped rather than in women's lives changed. Strategies for improving aid for women's health therefore concern effectiveness, not only volume. This answer sets out those strategies in detail: aligning aid with national plans and women's own priorities; harmonising and pooling donor effort; funding comprehensive women's health rather than narrow verticals; channelling money through and into stronger public systems; ensuring gender analysis and women's participation in aid decisions; making aid predictable, untied and results-accountable to citizens as well as donors; and building the transition to domestic financing. The principles of

the Paris Declaration on Aid Effectiveness (2005) — ownership, alignment, harmonisation, results and mutual accountability — extended at Accra and Busan, run through the discussion.

A working definition helps: aid for women's health is "improved" when more of each dollar reaches effective services for women — especially poor, rural and marginalised women — with less waste, less distortion of national priorities, and more durable capacity left behind when the project ends.

Strategy 1: National Ownership and Alignment with Women's Priorities

The foundational strategy is ownership: aid should fund what the recipient country's own health plan — developed with genuine participation by women's organisations, professional associations and communities — identifies as priority, rather than what donor headquarters currently favour. Ownership is not a courtesy; plans written in capitals without local authorship are routinely unimplemented, unstaffed and unsustained. Alignment is its operational twin: donors should use the country's own budgeting, procurement, reporting and audit systems wherever they meet reasonable standards, and invest in strengthening those systems where they do not, instead of building parallel project structures that drain ministry staff into donor-paid project units and collapse when funding ends. For women's health specifically, alignment means supporting the integrated package women actually need — antenatal, delivery and postnatal care, contraception, safe post-abortion care, screening, mental health — as one national programme, rather than importing five separately branded projects that share neither records nor referral pathways.

Gender-responsive priority-setting belongs inside this strategy. National plans and aid proposals should be required to show a gender analysis: which women, in which places, face which

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burdens; how the intervention reaches adolescents, unmarried women, women with disabilities, displaced women and the poorest quintile; and what sex- and age-disaggregated indicators will prove it. Aid that is gender-blind in design is reliably gender-unequal in result, because default systems default to the already advantaged.

Strategy 2: Harmonisation, Pooling and Reduced Fragmentation

The second strategy attacks fragmentation. A ministry of health in a poor country may deal with dozens of donors and hundreds of projects, each with its own reporting format, fiscal year, supervision mission and steering committee — a transaction-cost burden that falls hardest on the thinnest administrations, and each project separately too small to change a system. Harmonisation means donors coordinate among themselves: joint planning, joint reviews, common reporting, division of labour by comparative advantage, and, most powerfully, pooled funding — sector-wide approaches (SWAps) and basket funds in which several donors finance one national programme through one plan and one report. Pooled arrangements for reproductive, maternal, newborn, child and adolescent health have, in countries such as Bangladesh, Nepal and several African states, demonstrably reduced duplication and allowed governments to direct resources to neglected districts and services.

For women's health, pooling has a specific virtue: it can fund the unglamorous connective tissue that earmarked projects avoid — midwifery schools, referral transport, blood banks, maintenance, supervision and information systems — on which every vertical success silently depends. The corresponding discipline is that donors must accept shared credit and shared risk, and governments must offer the transparent financial management that makes pooling safe.

Table 1: Problems of aid for women's health and the strategies that answer them

Problem	How it harms women's health	Improving strategy
Donor-driven priorities	Funds fashions, not local burdens (e.g. mental health, NCDs neglected)	National ownership; gender-analysed country plans
Fragmentation	Parallel projects, duplicated reports, staff poached	Harmonisation, pooled / basket funding, SWAps
Vertical disease funding	Strong HIV or FP services beside empty maternity wards	Fund comprehensive, integrated women's health packages
Unpredictable, short cycles	Clinics open and close, staff contracts lapse	Multi-year, on-budget, predictable commitments
Tied aid and costly procurement	Money spent on donor-country goods at high prices	Untie aid; local and pooled procurement
Weak accountability to citizens	Reports go upward to donors, not to women served	Publish data; women's participation; social accountability
No exit or transition plan	Services collapse when projects end	Domestic financing growth; transition planning from day one

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Strategy 3: Fund Comprehensive, Integrated and Equitable Care

Third, the content of aid must be corrected. Global health financing has historically been vertical and disease-specific, and women's health has suffered a double distortion: within women's health, donor money concentrated on family planning and later HIV and maternal survival, while cervical cancer, breast cancer, mental health, menopause and ageing, disability, fistula repair and violence-response services remained chronically starved. An improving strategy funds comprehensiveness deliberately: it requires every large women's health investment to state how it connects to the full continuum of care, allocates protected shares to neglected areas, and integrates services at the point of delivery — for example, family planning,

HIV testing, cervical screening and violence enquiry offered in one visit, because a poor woman may reach a facility only rarely and cannot return separately for each silo. Equity is the companion test: aid should be explicitly pro-poor, with resource formulas weighted to underserved districts and with user-fee removal or insurance coverage for maternal and reproductive services, since fees are the point at which aid-funded systems most often still exclude the women they were built for.

Quality is part of content. Aid strategies increasingly and rightly fund respectful maternity care, provider training and supervision, clinical audit (including maternal death surveillance and response), and accreditation — recognising that a delivery service women fear or experience as abusive will not be used, however many facilities aid constructs.

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Strategy 4: Strengthen Systems, Workforce and Supply Chains

Fourth, aid should be judged by the capacity it leaves behind. System-strengthening strategies include financing the health workforce pipeline — especially midwives, nurses, lady health visitors and community health workers, the cadres who actually deliver women's care — with attention to rural posting, retention and supervision rather than training counts alone; building reliable supply chains for contraceptives, oxytocin, magnesium sulphate, antibiotics and blood products, where stock-outs are a direct cause of maternal death; investing in health information systems that capture women's health data disaggregated by age, sex, wealth and district; and funding infrastructure with its recurrent costs (staffing, utilities, maintenance) honestly budgeted, to end the familiar cycle of donor-built facilities standing empty. Technical assistance should build national capability — pairing, mentoring and south–south exchange —

rather than substituting for it with long-term foreign consultants whose reports leave with them.

A special case is humanitarian aid for women's health, where strategies include applying the Minimum Initial Service Package (MISP) for reproductive health in emergencies from the first days of a crisis — contraception, maternal and newborn care, prevention of sexual violence and HIV — rather than treating women's health as a later, developmental concern, and funding local women-led organisations, which reach affected women fastest and stay longest.

Strategy 5: Predictability, Untying, Accountability and Women's Voice

Fifth, the financial behaviour of donors must improve. Predictability: multi-year commitments, disbursed on schedule and recorded in the recipient's budget (on-budget aid), allow ministries to hire staff and plan services; erratic disbursement is a documented cause of clinic stock-outs and abandoned programmes. Untying: aid tied to purchasing from the donor country costs more and fits less well; untying aid and permitting pooled international procurement (as practised for contraceptives and vaccines) stretches every dollar. Transparency: publication of aid flows in open formats (such as the International Aid Transparency Initiative standard) and of results — including failures — allows parliaments, journalists and women's groups to follow the money. Accountability must run in both directions of the Paris framework: donors accountable to recipients for predictability and alignment, governments accountable to their own citizens, above all to the women whose health is the stated purpose, through published budgets, facility scorecards, community monitoring and grievance mechanisms.

Finally, women's participation is itself a strategy, not a consultation ritual. Women — including service users, midwives and nurses, disabled women's organisations and adolescent

representatives — should sit in the bodies that set aid priorities, review results and investigate complaints. Evidence and experience agree that services designed with their users detect obstacles (timings, privacy, fees, staff attitudes, transport) that planners miss, and that organised women's constituencies are the most durable defence of women's health budgets when political winds change. Looking forward, the sustainability strategy completes the list: aid should be designed from the outset to grow domestic financing — through tax-based budgets, social health insurance that covers women's care, and protected budget lines — with gradual, planned donor transition (as middle-income countries graduate from initiatives such as Gavi) rather than abrupt withdrawal. Aid that plans its own ending, and leaves a financed national system behind, is aid that has understood its purpose.

Conclusion

To conclude, improving aid for women's health is a matter of aligning money with need and with national ownership: fund one gender-analysed national plan rather than a mosaic of donor projects; harmonise and pool financing, and use country systems; pay for comprehensive, integrated, equitable and respectful care across women's whole lives, not only for fashionable diseases; invest in the workforce, supply chains and information systems that make services real; make funding predictable, untied and transparent, with accountability running to the women served and with women themselves at the decision tables; and build, from the first day, the domestic financing that will one day replace aid. The measure of success is simple to state and demanding to meet: that when the project closes, the midwife remains, the shelves remain stocked, the budget line remains — and women's health continues to improve because the system, not the subsidy, is carrying it.

Question 5: Short Notes — Mental Issues of Aging Women; Health Issues of Women in War Zones (10 + 10 Marks)

Write notes on the following: (a) Mental issues of aging women. (b) Health issue of women in war zone.

Part (a): Mental Issues of Aging Women

Introduction. Old age brings women a distinctive set of mental health risks, produced by the meeting of biological ageing with the losses and insecurities of a woman's social position. Because women live longer than men, the population at risk is large and growing, yet the mental suffering of older women is among the most neglected areas of health care in countries like Pakistan, where it is routinely dismissed — by families, by providers and by older women themselves — as the natural temperament of age. The main issues are depression, anxiety, dementia and cognitive decline, loneliness and grief, sleep disorders, and suicide risk, and each deserves separate notice.

Depression is the commonest mental disorder of older women and is consistently more frequent in women than in men at every age, including old age. Its drivers in later life are cumulative: widowhood and bereavement; chronic painful conditions such as arthritis; disability and loss of independence; poverty and financial dependence; neglect or conflict within the household; and the loss of roles that once gave status and structure to the day. Depression in older women is frequently missed because its presentation is often physical — aches, fatigue, appetite and sleep disturbance, repeated clinic visits with no findings — and because both families and doctors attribute low mood to "just age". Untreated, it worsens the course of every accompanying physical illness, accelerates cognitive decline, and raises

mortality. Anxiety disorders, including generalised anxiety and health anxiety, frequently accompany it, fed by insecurity about dependence, illness and being a burden.

Dementia, including Alzheimer's disease, is the second great mental health issue of ageing women, for two reasons: women's longer lives place more of them in the high-risk ages, and age-specific rates of Alzheimer's are also higher in women in many studies. Memory loss, disorientation, language difficulty and eventual loss of self-care transform an older woman's life and her family's; in settings without diagnostic services, dementia is often misread as normal ageing, wilfulness or even possession, delaying any support and exposing the woman to ridicule, neglect or abuse. Closely connected are loneliness and social isolation — the widowed grandmother whose children have migrated, whose friends and siblings have died, and whose mobility is restricted may pass days without meaningful conversation, a state strongly associated with depression, cognitive decline and physical deterioration. Sleep disorders, grief that becomes prolonged and disabling, fear of falling and of dependence, and the psychological effects of elder abuse belong to the same picture; and although suicide rates are highest among older men globally, older women's suicide attempts and self-harm — often by poisoning in South Asian settings — are a real, under-counted risk where despair, pain and family conflict combine.

The response begins with recognition: primary care and lady health workers trained to screen older women for depression and cognitive impairment, and to ask about loneliness, abuse and suicidal thoughts with the same routine seriousness as blood pressure. Effective help is mostly not exotic — treatment of pain and correctable conditions (thyroid disease, anaemia, vitamin deficiency, sensory loss), antidepressant medication where indicated, structured activity and

social contact (senior women's groups, religious and community participation, intergenerational programmes), bereavement support, respite and training for family carers of women with dementia, and protection against abuse. The feminist point made in Question 5 of Assignment No. 1 applies with full force here: much of the mental suffering of older women is manufactured by dependence, poverty and invisibility, and its deepest remedies are economic security, property, respect and a recognised place in family and society in their own right.

Part (b): Health Issues of Women in War Zones

Introduction. Armed conflict is a catastrophic health event for women, and its effects are broader and longer than the wounds of battle. War destroys the systems on which women's health depends — clinics, staff, supply chains, water and sanitation, transport and safety — at the very moment when violence, displacement, pregnancy and caregiving place women under maximum strain. The majority of the world's displaced people are women and children, and the health profile of women in war zones, from Syria, Yemen, Sudan and Gaza to Afghanistan and Ukraine in recent years, follows a consistent pattern described below.

The direct effects begin with death and injury from bombing, shelling, landmines and gunfire, in which civilian women are heavily represented in modern conflicts fought in populated areas. Sexual violence is systematically documented as a weapon and accompaniment of war: rape, sexual slavery, forced pregnancy and trafficking, perpetrated by combatants and also, in the chaos of displacement, by others — with consequences including injury, sexually transmitted infections including HIV, unwanted pregnancy in settings where abortion is unavailable, and profound, lasting psychological trauma compounded by stigma that may lead families to reject the survivor. Maternal and reproductive health collapses predictably: antenatal care and skilled

delivery disappear, caesarean sections become unavailable or dangerous, contraceptive supplies run out, and maternal and newborn deaths rise sharply — the majority of the world's maternal deaths occur in fragile and conflict-affected settings. Malnutrition follows the destruction of food systems, with pregnant and lactating women and the children they feed at highest risk; infectious disease (cholera, measles, polio where vaccination has lapsed) exploits ruined water systems and crowded camps; and chronic diseases go untreated as insulin, dialysis, cancer care and hypertension medicines vanish behind front lines.

The indirect and long-term effects are equally serious. Mental health disorders — post-traumatic stress disorder, depression and anxiety — reach very high prevalence among war-affected women, who must process their own trauma while holding families together, often after bereavement, widowhood and the loss of home and livelihood. Displacement itself is a health condition: camp and informal-settlement life brings overcrowding, unsafe water, no privacy or lighting (a direct risk for gender-based violence), loss of documents and entitlements, and dependence on aid; refugee women in host countries face language barriers, legal insecurity and exclusion from health systems. Adolescent girls in war zones face sharply elevated risks of early and forced marriage — used by desperate families as a perceived protection or economic strategy — school loss, and exploitation. Health workers, a largely female workforce at community level, are themselves killed, displaced and prevented from working, and attacks on health care, documented in many recent conflicts, convert hospitals from refuge into target.

The international response rests on international humanitarian law — the Geneva Conventions protect civilians, the wounded and medical services, and rape in war is a war crime and, in

defined circumstances, a crime against humanity — and on operational standards such as the Minimum Initial Service Package for reproductive health in emergencies, which prioritises maternal and newborn care, contraception, prevention and response to sexual violence, and HIV prevention from the onset of a crisis. Effective practice adds mobile and community-based care where facilities are destroyed, women health workers recruited from the affected community, safe spaces and case management for survivors of violence, mental health and psychosocial support integrated into primary care, and protection of aid access and of health facilities themselves. The conclusion drawn by every major review is the same: women's health in war zones fails not because its needs are unknown but because protection, access and funding arrive late or not at all — and because women, who hold war-affected communities together, are the last to be seated at the tables where ceasefires, aid and reconstruction are decided.

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Conclusion

To conclude, the two notes describe women at the two extremities of vulnerability — the older woman ageing into dependence, and the woman of any age caught in armed conflict — and they teach the same lesson from opposite directions. Mental suffering in old women and health collapse in war zones are both substantially produced by social arrangements: by poverty, dependence and invisibility in the first case, and by the destruction of protection and services in the second. Both are therefore partly preventable by social action: pensions, recognition and responsive primary and mental health care for ageing women; and protection of civilians and health care, immediate reproductive and mental health services, and women's participation in

peace and reconstruction for women in war. A health system, and a society, may fairly be judged by how it treats the women who can least compel its attention.

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