Women's Issues

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Democracy and Women's Health

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ABSTRACT

New research on broader determinants of health has culminated into the new paradigm of social determinants of health. The fundamental view that underlies this new paradigm is that socioeconomic and political contexts in which people live have significant bearing upon their health and well-being. Unlike a wealth of research on socioeconomic determinants, few studies have focused on the role of political factors. Some of these studies examine the role of political determinants on health through their mediation with the labour environments and systems of welfare state. A few others study the relationship between polity regimes and population health more directly. However, none of them has a focus on women's health. This study explores the interactions, both direct and indirect, between democracy and women's health. In doing so, it identifies some of the main health vulnerabilities for women and explains, through a conceptual model, how democracy and respect for human rights interacts with women's health.

Key Words: *Democracy; Health vulnerability; Human rights; Poverty; Social determinants; Women*

Introduction

Do we not always find the diseases of the populace traceable to defects in society?

(Rudolph Virchow, 1848 / 1985)

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My notion of democracy is that under it the weakest should have the same opportunity as the strongest.

(Gandhi, 1940)

Over the past two decades, research on various determinants of health that go well beyond the traditional biomedical and behavioural approaches to health and well-being have gained significant momentum. Increasingly, the upstream determinants of health, popularized in the emerging paradigm of *social determinants of health,* are being recognized and brought to the attention of policy makers. Integral to this paradigm are the roles of economic status—often captured by the level of income and its distribution or some measure of deprivation and poverty—education, employment status and working conditions, housing, early childhood development, social cohesion and inclusion, gender, race, systems of social security, and equitable access to appropriate health care.

The fundamental view that underlies this new paradigm is that socioeconomic and political contexts in which people live have significant bearing upon their health and well-being. Numerous studies have documented the contribution of socioeconomic factors to individual and population health. Also, a few studies have investigated the (indirect) role of political factors on health and quality of life through their mediation with the labour market relationships and the welfare state institutions and policies in a number of (mostly European) countries (Navarro, 2004). Even fewer studies have explored the direct effects of political factors and systems on people's health.

The role of democracy and political freedom in population health has been recognized as early as the mid 19th century by the prominent pathologist Rudolph Virchow (1948/1985). Since then, however, such factors have been totally ignored in subsequent studies of the etiology of disease and population health. There are a few exceptions, however. One study (Lena and London, 1993) examines the impact of regime ideology on measures of population health and mortality rates. They find that, in general, high levels of democracy and strong left-wing regimes are associated with positive health outcomes. Another study (Shandra *et al*., 2004) considers the role of political democracy, along with a set of socioeconomic indicators on infant mortality rates in a sample of 50–60 developing countries. However, the results of this study for the separate role of political democracy are neither statistically significant nor empirically conclusive. Yet another study (Franco *et al*., 2004) investigates the effect of democracy on some measures of population health. This study finds longer life expectancies and lower infant and maternal mortality rates in "partially free" and "free" countries compared with "not free" countries. Such categorization of countries is based on the country rankings of democracy by the Freedom House (2008). In a more recent study (Ruger, 2005), the link between democracy and health in

China is noted by looking into three epidemics of famine, SARS (Severe Acute Respiratory Syndrome), and HIV / AIDS. The study blames the authoritarian regime in China for the massive death and hardship resulting from those epidemics. Finally, in two related studies based on different methodology and data, the role of political freedom and democracy on a number of measures of population health for both men and women across a large sample of developing and developed countries are examined (Safaei, 2005, 2006). The latter studies find that democracy is consistently associated with better health, in terms of lower mortality rates and higher life expectancies.

Although both studies consider the effects of democracy (or lack thereof) separately for men and women, they are not dealing with women's health *per se*. This article explores the implications of democracy and human rights for women's health and well-being. In so doing, it first articulates some of the main health risks and vulnerabilities to which women are particularly exposed. It then uses a conceptual model to configure and explain, in broad terms, how democracy and respect for human rights could affect various manifestations of women's health vulnerabilities as previously identified. Finally, it provides some aggregate international data as a partial support for the conjectured relationships in the conceptual model.

Women's Health Risks and Vulnerabilities

Congruent with studies on social determinants of health over the past 30 years, research on women's health and well-being has been expanding. Although it is difficult to summarize the evolution of this research in this limited space, some of the key themes and areas of focus of this vast literature as related to human rights and democracy are identified below.

Aside from the risks and health-threatening exposures common to all human beings, women by virtue of their sex are vulnerable to many threats to their health and, as it happens, to their lives. Some of these threats may be sporadic or situational, but most of them are deeply rooted in the persistent social structures that reproduce and perpetuate stratified societies in which systematic inequities and discrimination against women are tolerated, if not readily condoned. The following categorization of risks to women's health is by no means complete. Also, the categories are not mutually exclusive, and at times, they may be confounding to exacerbate women's ill health.

Risks of Sexual Exploitation and Violence

Women's sexuality has been a major risk for health and well-being of women over time and across space. This major risk has manifested itself in various forms of sexual exploitation, coercion into unsafe sexual relationship, rape, forced pregnancy, female genital mutilation, trafficking and sexual slavery, and

violence by intimate partners and nonpartners. Expectations for sexual favour from women in return for employment and other opportunities are prevalent in many parts of the world. Lacking the right to own or inherit land and property leaves women and girls exposed to increased sexual exploitation and violence, especially after the death of their partners or parents. In more serious situations, like during humanitarian crises, girls and women who are faced with limited economic opportunities may be forced into alliances with military forces, including peacekeepers and humanitarian personnel, to survive or support themselves and their families (UNICEF, 2003). Violence against women has been documented in many studies (e.g., Koss, 1993; Golding, 1996; Heise *et al*., 1999; Lievore, 2003; Kishor and Johnson, 2004; Naved *et al*., 2006; Gross *et al*., 2006; Dasgupta, 2007; Castro *et al*., 2008). Such studies show significantly high prevalence rates, albeit variable across countries, of sexual and physical abuse toward women. World Health Organization (WHO) estimates that about 100–140 million girls and women in some 28 countries have undergone some form of female genital mutilation, with the highest incidence in parts of Africa (Sen *et al*., 2006). The WHO Multicountry Study on Violence against Women (WHO, 2005) reports the proportion of ever-partnered women who had ever experienced physical or sexual violence, or both, by an intimate partner in their lifetime in the range of 15–71%. For nonpartner violence after the age of 15, the figures ranged from 5% to 65% (WHO, 2005). The consequences of injuries from physical and sexual violence for women's physical and mental health are substantial. They include cuts and bruises, permanents disabilities, sexually transmitted infections, HIV infections and AIDS, unwanted pregnancies, gynecological problems, miscarriages, still birth, chronic pelvic pain and pelvic inflammatory disease, depression, post-traumatic disorder, and suicide (Sen *et al*., 2006).

Reproductive Health Risks

Pregnancy, child birth, and puerperium put women through significant physiological, physical, and emotional changes with their consequent health risks. Each year, an estimated 210 million women have life-threatening complications of pregnancy, often leading to serious disability, and a further half a million women die in pregnancy, child birth, and the puerperium, nearly all of them in developing countries (WHO, 2004a). Each year 80 million women have unwanted or unintended pregnancies, 45 million of which are terminated (Alan Guttmacher Institute, 1999). Of the 45 million abortions, 19 million are unsafe, and about 68,000 women die every year from complications of unsafe abortion (WHO, 2004b). Moreover, an estimated 340 million new cases of four common sexually transmitted bacterial and protozoan infections are acquired every year, contributing to infertility of more than 180 million couples in developing countries (Rutstein and Shah, 2004). Nearly 5 million new HIV infections (UNAIDS, 2005) and 257,000 deaths from cervical cancer (Mathers and Loncar, 2005) add to the enormous burden of morbidity and mortality related to the reproductive role of women.

Health Risks of Child Rearing and Domestic Work

Aside from the risks of morbidity and mortality from maternity, women endure hardship feeding, tending, and caring around the clock for their children. Although they may endure it out of their unconditional love for their children, the tax on their health from such intensive care cannot be ignored. In the absence of institutional care outside of the family in most developing countries, women are tasked to take care of their many children, often without any support from other members of the family. In addition, they are responsible for doing most, if not all, of domestic chores, preparing food, and providing comfort for their husbands. The burden of domestic work prevents women from seeking paid employment outside the home. However, when they manage to obtain paid work in the formal sector, they are most often double-burdened with that job as well as household chores. Moreover, in rural areas of many developing countries, women work the land along with their household duties. The toll on women's health of such immense burden, though significant, is not easy to quantify.

At the same time, women are traditionally tasked with the care of the sick and elderly members in their immediate or extended families. This so-called "labour of love" rests on the caring and affectionate nature of women as mothers. Again, the lack of institutional or community based care as well as prevalent social norms put extra burden on women for the routine care of the sick and old.

Discriminatory Sociocultural Practices and Attitudes toward Women

By and large, all societies bear a certain degree of discriminatory biases against women. Such biases are often deeply entrenched in social norms and cultural rituals of various societies. Traditional societies that are typically underdeveloped witness a more pronounced prevalence of discriminatory behaviours toward women. In these highly gendered societies, those who wield gender power (obviously men) in family, community, and religious hierarchies fiercely resist any threat to their interests, which may arise from groups of women or their advocates asking for justice and a more equitable share of decision making power. Examples of socially condoned discriminations that have direct consequences on women's health and well-being include the age-old custom of *chhaupadi* (a social tradition in the western part of Nepal that prevents Hindu women from participating in normal family activities during menstruation because they are considered impure, forcing women out of the house to live in the shed with cows and other animals; Sen *et al*., 2006), various forms of female genital mutilation, marriage of under-age girls, honor killings, sex-selective abortion, female infanticide, domestic violence, and polygamy. The physical and mental ill-health consequences of such discriminatory practices are hard to fathom. Also, as a result of discriminatory traditions, often built into laws, women are denied entitlement to land and other property, are deprived of inheritance, and are given little say, if any, in matters of divorce and child custody. These injustices

simply drive women into greater depths of insecurity and poverty.

Poverty and Economic Inequalities

Poverty and economic inequalities are not unique to women. However, women shoulder a much bigger burden of deprivation and lack of economic opportunities. More than 1 billion people live in poverty around the world, and a great majority of them are women (UN-INSTRAW, 2005); the annual death toll from poverty-related causes is around 18 million (WHO, 2004c). The copious literature on development is replete with narratives and evidence on women's economic subordination, insecurity and vulnerability. However, such adversity is not necessarily the result of underdevelopment. Women face deprivation and inequity even in the most developed countries, albeit to a far lesser extent.

The distribution of income and other economic resources within the families, even the well-to-do ones, is not equitable in many societies. The male members of the family often claim a bigger share of such available resources. This maldistribution is even more serious for very poor families, where the issue is not having a little more or less, but one of survival. Moreover, women have the added responsibility of nursing and feeding their children out of their own share of the food, which further undermines their health in view of their more than proportionate share of burdensome duties within the families.

Despite a high and growing global average income, billions of human beings are still condemned to life long severe poverty, with all its attendant evils of low life expectancy, social exclusion, ill health, illiteracy, dependency and effective enslavement (Pogge, 2005). The root cause of poverty and economic injustice is in the highly stratified structures of societies that divert resources and opportunities to those in positions of power and status. The gulf of inequity between the rich and the poor, who are predominantly represented by women and children, has been growing wide and deep over time and across the world, especially in recent decades because of globalization.

Poverty robs people of their very basic necessities of life, assaulting their human dignity and minimizing their capacity to sustain life and avoid illness and death. "More importantly, the poor, assailed by life's vicissitudes and society's callousness, may learn to accept their fate and sink further into the morass of poverty, disease and deprivation" (Singh and Singh, 2008).

Poverty is the mother of all ills. This simple yet stark reality has been conspicuously disregarded in public discourse and health policy debates throughout history. Thanks to conscientious scholars, advocacy groups, and citizens concerned with the fate of the poor and disadvantaged, issues of poverty and inequality as related to health have recently been brought to the forefront of debates on public health and economic well-being. However, despite numerous

initiatives, legal tools, national and international conferences, resolutions, and conventions, the number of women living in poverty has been steadily increasing (UN-INSTRAW, 2005). The world has still a long way to go to address poverty and inequality in any meaningful and effective way.

Although poverty and inequality has been considered as a distinct category of women's health risks and vulnerabilities, in light of the above discussion, it must be emphasized here that women's impoverishment and economic dependence is the main contributor to the other health vulnerabilities and risks to which women and girls are subjected. The persistence of unjust socioeconomic conditions and their horrendous implications for ill health of the poor has been referred to as *structural violence* by the well-known physician-anthropologist Paul Farmer (2005). This is a fundamental violence that allows and perpetuates all other manifestations of violence toward the weak and the oppressed, as women are in many societies.

If women are to gain their respectful rights to dignity, independence, self-worth, and be able to actualize their selves and live a full, meaningful and healthy life they so deserve, they have to be free from the subjugation of structural violence and their human rights reinstated. This leads us to a discussion of the role of human rights and democracy in women's health.

Before we do so, in the light of the above, it may be asked, "Are the risks to women's health examined above, that is, risks of sexual exploitation and violence, reproductive health risks, health risks of child rearing and domestic work, and discriminatory sociocultural practices and attitudes toward women less in democracies? And if so, what is the available evidence?"

The discussion in the next section and presentation of some aggregate data in the following section will shed some light on the above questions. Suffice to say at this point that the extent of those risks as confounded by the lack of adequate services and support available to women are most likely greater in nondemocratic countries than in democratic ones. Moreover, lack of freedom of the press, widespread censorship and approving social norms in many nondemocratic countries lead to systematic underreporting of incidents related to those health risks (Lievore, 2003).

Democracy, Human Rights, and Women's Health

Notwithstanding the shortcomings of democracy as practiced today, it is yet the best system of political organization that humankind has come up with. It is a system that allows people to voice their concerns and provides the opportunity to recognize all the rights to which humans are entitled. After a very long time in human history, it is fairly recently that, with the advent of democracy and

representative governments, human rights have been explicitly identified and recognized. Such rights were popularized with the adoption and proclamation of the Universal Declaration of Human Rights by the United Nations in 1948 in recognition of the inherent dignity and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world (United Nations, 1948). They have been refined and extended with subsequent international, regional, and national covenants and conventions.

The right to health, as a human right, has been distinctly recognized by the WHO. Although the definition of health by WHO is imaginatively broad and wholesome, its interpretation by national governments and health authorities in various countries has usually been restricted to the right to *access health care*. Ensured access to effective health care for all, especially for women and children, is definitely a giant step forward. However, this fundamental step has yet to be taken by the authorities in many developing countries, especially the more impoverished ones (Singh and Singh, 2004).

The right to health, even in its restricted sense, would call for resources and policies to provide adequate and accessible services and support for women facing various health risks with a great promise to improve their health and well-being. A major portion of those resources would be best spent in female education with a focus on health-improving and health-preserving practices.

More importantly, however, in light of the recent recognition of the role of socioeconomic and political factors in population health, the right to health must be understood as the right to all economic, social, and political entitlements that so fundamentally defines and shapes our health and well-being. Women, and the poor majority, would far greatly benefit from policies aimed at eradication of poverty, income redistribution through social security systems, recognition of their reproductive rights, abolition of all discriminatory social barriers to ownership and education, and effective participation in social as well as political domains, than those policies directed solely at increased access to *curative* health care. The former policies *prevent* women from suffering and ill health, whereas the latter, as laudable as they are, would only *manage* the symptoms of suffering and sickness.

A Conceptual Model

The pathways through which democracy affects women's health outcomes are varied and complex. In what follows, some of the direct and indirect pathways are identified. The notion of democracy that underlies the discussion here is one of *institutionalized* democracy, which is conceived as three essential and interdependent elements: (1) the presence of institutions and procedures through which citizens can express effective preferences about alternative policies and leaders; (2) the existence of institutionalized constraints on the exercise of

power by the executive; and (3) the guarantee of civil liberties to all citizens in their daily lives and in acts of political participation (Marshal and Jaggers, 2002). Other aspects of plural democracy, such as the rule of law, systems of checks and balances, freedom of the press, and so on are considered as means or specific manifestations of these essential elements (Marshal and Jaggers, 2002).

To organize the ideas and identify the pathways through which democracy interacts, both directly and indirectly, with the health and well-being of women, the schematic model shown in Figure 1 may prove useful.

Direct Pathways

Democratic regimes are expected to uphold their citizens' human rights and dignities and provide mechanisms by which such rights are actualized. To the extent that they do so, they create an atmosphere of mutual respect and a supportive environment which breeds positive feelings of self-worth, optimism, and hopefulness among their populace. This has been extremely important for women whose rights and dignities have historically been trampled upon by the tyranny of authoritarian regimes and the unjust, rigid, and crippling social

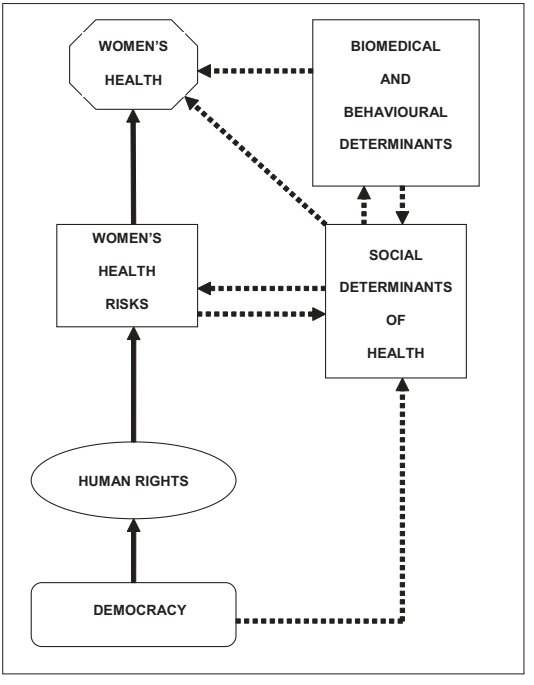

Figure 1: A schematic model of interactions between democracy and women's health (Note: Direct interactions are identified by bold arrows, and indirect ones are identified by broken arrows.)

traditions they support. Women are increasingly finding their rightful place in various arenas of social and political life and are demanding their rights to self-determination, and their entitlements to an equitable share of society's resources that they have been denied for so long.

Upholding the rule of law and protection of the vulnerable against aggressions of the powerful in democratic countries has significantly reduced systematic violations of women's rights and dignities. It is true that pockets of violations happen here and there in democratic countries, but that is no comparison to the gross, systematic, and widespread violations of women's right in the undemocratic ones. The aforementioned health vulnerabilities of women—including sexual exploitation and violence, reproductive and childbearing health risks, burdens of child rearing and care for the sick and elderly, domestic labour and harsh work in the field or factory, discriminatory traditions and social biases, and poverty and economic inequality—have been drastically reduced in varying degrees in democracies as a result of recognition and respect for women's rights.

Thanks to free and accessible education, free press, and relatively free flow of information in democracies, girls and women are increasingly aware of their rights. Through various associations, advocacy groups, media outlets, and civil societies, they have been able to voice their opinions and have much of a say in matters of significance in their lives. However, women of most developing countries are still chained in repressive traditions and oppressive regimes that deny them their right to self-expression. In an environment of widespread censorship no real debate of important women's issues takes place and usually policies are designed from a male gender perspective that surely miss the insights and the interests of women for whom such policies are unilaterally prescribed. The harm from such policies for women's health is all too well known.

Indirect Pathways

In addition to the above direct interactions, democracies interact with women's health indirectly by affecting the socioeconomic determinants of health. Patterns of ownership of economic resources, distribution of income and wealth, access to employment opportunities, social security provisions, and socioeconomic mobility are more equitable for women in democratic countries. This is not to deny the fact that there is still significant gender inequity in democratic countries. Equity is not guaranteed by political freedom alone. A commitment to social equality and solidarity and true respect for human rights must come from a moral perspective that cares about society as a whole, and not the interests of the powerful minority. That is why countries with a social democratic political tradition have fared so well in improving the lot of their people, women in particular, in achieving economic prosperity and improved health and well-being, as compared with democratic countries with liberal or other political philosophies. For example, for the period 1950–1998, the infant

mortality rate was lowest in the *social democratic* countries (e.g. Sweden, Norway, Denmark), followed by the *Christian democratic* countries (e.g. Germany, France, Netherland), then followed by the *liberal* countries (e.g. Canada, United Kingdom, Ireland). For the same time period, female (as well as male) life expectancy at birth was highest in the social democratic countries, followed by the Christian democratic countries, and then followed by the liberal countries (Navarro *et al*., 2004).

The superior performance of the social democracies has significant implications for both democratic and nondemocratic countries. It signifies to the democratic countries that improving the health and well-being of all people requires a genuine commitment to social well-being as opposed to the well-being of a segment of the population which is influential in supporting the current government and reelection of the next. To the nondemocratic countries, it sends the message that upholding the ideals of socialism would only be possible in a free and truly democratic society, and not in the ideological dictatorships pretending to uphold the interests of people.

In a majority of politically repressed developing countries, especially in Africa, issues of poverty, injustice, corruption, and the like for both women and men are yet to be acknowledged, let alone being voiced or addressed. Many people in these countries have been looking to developed countries as a window of hope, yet the international community has failed to assist them in their struggle for freedom and prosperity. The conditional, and often misguided, support of the international community as provided through international agencies has not addressed the fundamental issues of human rights violations by the aid receiving countries which are often ruled by corrupt and oppressive regimes. The recent tragedy in Burma is an extreme example of how far a dictatorship would go to deprive its people from the vital necessities offered by donating countries. As it happens, during natural or manmade disasters, it is the women and children who suffer most, simply because they are too weak to assume their rightful entitlement and more vulnerable to such disastrous situations.

Public health measures, such as access to safe water, sanitation and sewage disposal, food and nutrition, are known to be more important in disease prevention and reduced mortality than medical interventions. Such health measures require nationwide investments in physical infrastructure, environmental safety, as well as educational and extension programmes, that need to be directed mostly at women as the caregivers of children and other household members, all having significant claims to public resources. Democratically representative and accountable regimes have been committed to such investments and have realized significant improvements in increased life expectancies and reduced mortality rates in their populations, even though there is still some degree of health inequality along gender, ethnic and socioeconomic dimensions.

Despite increased economic opportunities for women and the narrowing gender inequality in democratic countries, women are often too burdened with the responsibilities at home and may be unwilling, or unable, to take full advantage of the opportunities in furthering their economic status. In recognition of such commitments by women, systems of welfare state or social security that vary in their generosity and reach have been developed in all democracies starting as early as late forties and fifties. These measures grew out of concern for the poor and less privileged, mainly in response to the strong demands by organized labour, and activists for women's rights. That is why such programmes are more generous in Scandinavian democracies with pro-labour institutions and stronger women's coalitions. Most undemocratic societies have either no social security plans in place, or at best, some partial measures that have a limited reach and are often too frugal. People in the latter countries must press their governments for establishing and expanding social security programmes, especially for the women who are often insecure and unprovided for. By the same token, the international community should direct its support and assistance in furthering social welfare programmes in poor countries, reversing the current policy of dismantling such programmes.

A question maybe asked here, "How is Figure 1 different in other governances? If the term 'Democracy' there were to be replaced by 'Dictatorship,' or other polities, how would the interactions change?"

Given the general nature of the conceptual model, there would be no difference in Figure 1 if "Democracy" was replaced with "Dictatorship." The differential impacts of democracy versus dictatorship would be reflected in the differential health outcomes that women would experience under either polity (i.e., better women's health for democracy, and worse for dictatorship). And that would be a crucial difference from the study's point of view here.

Some Aggregate International Data

To provide some empirical support for the conjectured relationships in the conceptual model, Table 1 below reports the average measures of health outcome along two indices of democracy. The health outcomes include female life and healthy life expectancies at birth, maternal mortality ratio, and female mortality rate. As well, neonatal, infant, and child (under 5 years) mortality rates are considered because they are closely related to women's health and well-being. Given the higher rates of TB and HIV / AIDS among women, prevalence of TB and HIV / AIDS for the entire population is also included. Such data were not available for males and females separately. Data on health outcomes for four categories of countries—low-income, lower middle-income, upper middle-income and high-income countries—are taken from World Health Report 2008 (WHO, 2008).

Table 1: Average health outcomes and governance scores by income groups

Health outcome	Countries			
	Low Income	Lower-Middle Income	Upper-Middle Income	High Income
Female life expectancy at birth (years)	60	73	73	82
Female healthy life expectancy at birth (years)	50	63	66	73
Maternal mortality ratio (per 100,000 population)	650	180	91	9
Adult mortality rate (per 100,000 population)	254	115	145	62
Neonatal mortality rate (per 1000 population)	40	19	12	4
Infant mortality rate (per 1000 population)	73	27	22	6
Child mortality rate (per 1000 population)	110	35	26	7
TB prevalence (per 100,000 population)	362	188	121	17
HIV/AIDS prevalence (per 100,000 population)	1039	239	1484	249
Mean Governance Score 1	–0.749	–0.431	0.0280	0.876
Mean Governance Score 2	–0.940	–0.447	0.095	1.194

The two indices of democracy are the average score of governance for *Voice and Accountability* (Score 1), and the average score of governance for the *Rule of Law* (Score 2) as provided by Worldwide Governance Indicators (Governance Matters, 2008) for more than 200 countries around the world. Each score ranges from –2.5 to 2.5. Although there are scores on other aspects of governance, these two scores appear to better capture the spirit of democracy. The closer the score to the upper limit of this range the higher the level of good governance or democracy in a country. For each group of countries, the governance scores of the member countries were averaged to obtain the mean score of governance for that group.

Despite some idiosyncrasies for the measures within each group of countries, the average measures of health improve clearly as we go from low-income countries to the high-income countries. If we approximate the socioeconomic conditions in a country by their average income, such observed health gradient along average income may be taken as an indication of the role of socioeconomic determinants on health. More pertinent to the focus of this study is the consistent improvement in the two indices of democracy (Scores 1 and 2) from low-income to high-income countries. To disentangle the direct interactions between democracy and women's health outcomes from indirect ones, a statistical analysis of individual countries would be needed. Such analysis is beyond the scope of the present study, but could be its logical extension in a future work. Nevertheless, it should be helpful to explain here broadly how one might ago about isolating the effect of democracy on women' health from other confounding factors such as income. To capture the separate impact of democracy on women's health, one needs to regress measures of women's health on scores of democracy along with socioeconomic measures from individual countries in a multiple regression model. Short of that, one could examine the association or correlation between

democracy and women' health *within* each group of countries with similar income (e.g., low-income countries). However, the latter would be a crude way of disentangling the effect of democracy on women's health as it fails to control for other nonincome socioeconomic factors.

Notwithstanding the need for a detailed analysis, the aggregate data provided in Table 1 do support the conjectured interactions in the conceptual model, namely, that democracy improves the health and well-being of women upholding their human rights and enhancing their socioeconomic position.

Concluding Remarks

1. Determinants of health go well beyond traditional biomedical and behavioural factors. They include socioeconomic and political contexts that surround populations.
2. Political regimes have significant bearing on their people's health directly through their treatment of human rights and indirectly through the socioeconomic structures they support.
3. Women around the world bear a greater share of the burden of diseases because of vulnerabilities related to their sex.
4. Sexual exploitation and violence, reproductive health risks, child rearing and domestic labour, care for the sick and elderly, discriminatory traditional and cultural impositions, and poverty and inequality, are among the main health vulnerabilities threatening women's health in many developing countries.
5. Women's health vulnerabilities are a direct result of their human rights violations.
6. Democracy will significantly improve women's health and well-being by upholding their human rights and providing opportunities for them to narrow the inequality gap with men.
7. Because of improved socioeconomic conditions and respect for women's rights, democratically developed countries show great improvements and lesser inequities in their women's health. Here is a loud and clear message for the leaders and development professionals in developing countries to listen to, if they so choose.
8. Democracy must be combined with a moral perspective that cares for the good of all, if we are to end inequities and injustices, particularly for women, in our societies.

Take Home Message

1. Socioeconomic and political factors are very important for health.
2. Democracies make substantial contribution to women's health by way of improving their socioeconomic conditions and respecting their human rights.
3. Developing countries must democratize to ensure their development efforts benefit all, especially the poor women and children.

Conflict of Interest

None declared.

Declaration

I declare that this is my original unpublished work, and has not been submitted for publication elsewhere.

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Questions That This Paper Raises

1. What contributes to health and well-being?
2. What are the health risks to which women are uniquely exposed?
3. How do we reduce or eliminate women's health risks?
4. How does democracy interact with women's health?
5. Can democracies cope with local traditional and cultural practices?
6. Is improved health and well-being a precondition for democracy, or a consequence if it?
7. Why is it that numerous international initiatives, conventions, and agreements on reducing poverty and inequality around the world have failed to improve the fate of poor women in developing countries?
8. Is a democratic government enough for ensuring equitable distribution of resources and opportunities?

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