Gender Dimensions of Poverty and HIV/AIDS : A Statistical Review of Six Countries

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Although no country treats its women as well as its men, women are by no means a homogeneous group. Without examining the differences among them, especially those that arise from income groupings, ethnicity and geographic location – notably the rural/urban divide – policy-makers risk increasing not only gender discrimination, but other obstacles to reaching the MDGs. An examination of six developing countries points to areas in which data deficiencies stemming from gender blindness distort poverty reduction policies.

Millennium Development Goal 3 – Promote gender equality and empower women – in fact cuts across all seven others and calls for "engendering" the development paradigm itself, along with any policy framework formulated for that model. Gender-specific information, statistics and data, disaggregated in various planes – income class, location, and social groups – are therefore crucial to achieving both. Given this broad perspective, this article focuses on mobilising gender-specific information in two areas – human poverty and HIV/AIDS – for six countries: Botswana, Cambodia, Namibia, Nepal, India, and Turkey.

These countries offered two advantages:

- A diverse sample — large populations (India) and small (Cambodia); contrasts in terrains, such as mountains (Nepal) and plains (Botswana); low-income situations (Namibia) and high-income ones (Turkey); culturally diverse societies (India) and homogeneous ones (Botswana); conservative attitudes towards women (Nepal) and progressive gender traditions (Turkey).

- Specific concerns — a focus on HIV/AIDS and its impact on women (Botswana and Namibia) and gender gaps along ethnic and caste lines (India).

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They also offered ready availability of data on seven indicators vital to reaching the MDGs:

- Incidence of income poverty (Goal 1: Eradicate Extreme Poverty and Hunger)
- Access to productive resources, e.g. land ownership and institutional credit (also a factor of Goal 1)
- Literacy rates and enrolment ratios (Goal 2: Achieve Universal Primary Education, Goal 3)
- Mortality rates (infant, under-5 and maternal) (Goals 4 and 5, respectively, Reduce Child Mortality and Improve Maternal Health)
- Life expectancy and survival rates (Goal 1, as well Goals 4 and 5)
- Incidence of HIV/AIDS infection and its impact (Goal 6: Combat HIV/AIDS, Malaria and Other Diseases).
- Access to basic social services – health, safe water and basic sanitation (Goal 7: Ensure Environmental Sustainability, as well as Goals 4, 5 and 6)

Disaggregated from various distributional perspectives, the data presented in this paper not only highlight the global gender gap, but show how various dimensions of impoverishment overlap and reinforce each other and how outcome variables, such as mortality rates, are linked to input variables, such as access to social services. This, in turn, helps us to evaluate development policies; to link them to gender deprivations and to assess the gender specificity of these disadvantages; and to identify their gender biases. Last, but hardly least, it highlights some of the constraints, both methodological and practical, in gathering gender-sensitive data and points to ways of overcoming these obstacles in our efforts to reduce both poverty and HIV/AIDS.

Whatever the intentions of decision-makers, no development policy is gender-neutral. The very dearth of gender-disaggregated data worldwide indicates a bias against women and girls. But, by the same token, no policy can effectively address gender bias, let alone poverty or AIDS, unless it takes into account the gender disparities manifest in differing sectors within various socioeconomic, cultural and location-specific groups.

A Sectorial Overview

Gender disparity cannot be used as a blanket term. The nature and extent of disparity among different population groups revealed by the countries in this article's sample clearly indicate that other socioeconomic realities and institutional complexities interact with each other to determine the end results.

Table 1. Overall gender disparity: Botswana and Nepal, 1995

	Botswana		Nepal	
	Female	Male	Female	Male
Life expectancy at birth (in years)	68	65	52	55
Adult literacy rate (%)	70	67	21	54
Combined primary, secondary and tertiary enrolment rate (%)	70	70	52	67
Shares in earned income (%)	39	61	17	83
Shares in administrators/managers (%)	36	64	9	91
Seats in Parliaments (%)	18	82	3	97
Seats in District Councils (%)	23	77	7	93

Source : UNDP (1997) and Nepal South Asia Centre (1998)

Despite the differences in experiences, however, certain universal trends are manifest in terms of direction, if not necessarily degree. We can distinguish some of these generalised phenomena in the following areas:

Health

Women everywhere seem to enjoy a natural biological edge over men, which is reflected in their higher life expectancy. One exception is Nepal, where male life expectancy is higher than female. This anomaly, though, results from the disproportionate deprivations and neglect that Nepalese women experience during their lifetime. As in most other countries, the infant and child mortality rates of girls in Nepal are lower than those of boys. But the advantage the girls have in terms of mortality during their first few years of life is more than nullified later. In Namibia, the present marginal edge women have over men in life expectancy is expected to disappear by 2010, primarily due to the impact of HIV/AIDS, which will have a significantly higher adverse impact on women.

Table 2: Girls do better than boys in health outcomes, but not in health access, 1996

	India		Namibia		Turkey	
	Girls	Boys	Girls	Boys	Girls	Boys
Infant mortality rate (per 1,000 live births)	84	88	54	58	66	70
Children under-5 severely stunted (%)	48	49	27	32	18	20
Prevalence of diarrhoea (%)	10	11	22	23	22	25
Prevalence of acute respiratory infection (%)	7	8	17	21	12	13
Diarrhoea patients seen medically (%)	57	64	67	70	27	29
Respiratory patients seen medically (%)	65	70	65	67	38	39

Source : Gwatkin, Davidson R. et. al (2000a, 2000b and 2000d)

Girls in general are better off in various health outcomes. Thus, in terms of infant mortality, child mortality, and child stunting, girls do better than boys (see Table 2). This is partly because the incidence of various diseases is lower among girls, primarily due to their biological resilience rather than better access to health services or medical treatment. In terms of access and treatment, in almost every situation, the bias is in favour of boys.

Maternal health figures underline this bias. A major issue in most countries where data are available (Cambodia, India and Nepal), the maternal mortality ratio in each exceeds 400 per 100,000 live births – a ratio comparable only to Sub-Saharan Africa. It arises in part from poor access to and utilisation of maternal health services, low quality health facilities, insufficient access to birth spacing information, supplies and services.

Domestic violence, suffered disproportionately by women globally, also manifests itself in all six countries. In Cambodia, a household survey in Phnom Penh and six provinces shows that 16% of all women surveyed reported being physically assaulted by their husbands and that about half sustained injuries because of abuse. Domestic violence has become a multidimensional problem in Botswana (see Box 1). In India, conservative estimates put the number of bride-burnings for non-payment of dowry at 5,000 per year.

Box 1. Domestic violence in Botswana: a multidimensional problem

As the table below on reported cases of violence against women indicates, domestic violence in Botswana has taken different forms — from rapes to unlawful wounding. And in a majority of cases, the offenders are not punished or convicted. For example, between 1984 — 91, the number of rape cases reported, on average, were more than 400 per year, but only 25% of the offenders were convicted. In the 1990s, the situation even became more serious. In 1991, out of 700 reported rape cases, only 150 offenders were convicted.

	1997	1998	Increase (%)
Rape	1183	1310	11
Threats to kill	102	152	49
Unlawful wounding	1367	1479	8
Assault leading to actual bodily harm	4734	5502	16

Source : Government of Botswana (1999c)

Education

Except for Botswana, the results show stark contrasts. In Botswana, women now lead in terms of literacy and enrolment rates, but all five other country studies manifest a bias against women, though in varying degrees. In Namibia, for example, the female adult literacy rate is 80% compared to 82% for males, but in India the comparable figures are 45% and 68% (see a breakdown by socio-religious groupings in Table 3). The gaps in enrolment rates are also wide in some cases. In Nepal, female net primary enrolment rate is 56% compared to 80% for boys. The disparity increases with the level of education, as one moves from primary to secondary to tertiary level. In Turkey, new enrolments among women at the tertiary level are still less than 60% of that of men, even though at the primary level it is 90% and at the secondary level it is 75%.

Table 3. India – diversified educational outcomes among different social groups

	Scheduled caste		Muslims		Hindus	
	Female	Male	Female	Male	Female	Male
Literacy rate (%)	28	53	38	60	39	66
Primary net enrolment rate (%)	55	70	57	66	65	78
Discontinuation rate (%)	9	6	7	3	8	5
Completing secondary level (%)	2	7	3	8	5	12

Source : Shariff, Abusaleh (1999)

Table 4. Benefits of women's education: the Cambodian case, 1997

	Percentage increase in monthly earnings compared to employees with no schooling	
	Female	Male
Primary	32	10
Lower secondary	65	35
Upper and post-secondary	80	4239

Source : Kingdom of Cambodia (1997)

Mothers' schooling level	Child's school level	Gross enrolment ratio Female	Male
None Primary Post-primary	Primary	87 99 104	104 111 112
None Primary Post-primary	Lower secondary	12 29 60	28 42 73
None Primary Post-primary	Upper secondary	2 8 28	7 17 39

Source : Kingdom of Cambodia (1997)

Moreover, inequaliries in education becomes a critical factor for outcomes in other human development areas, including income poverty, as Table 4 shows for Cambodia.

Economic Indicators

Overall, gender disparities increase as one moves to the economic arena, as reflected in workforce participation rates, economic activity rates, wage rates and earnings. The gender gap in distribution, share of employment and earnings is large even in Turkey, long known for its progressive gender attitudes (see Table 5).

Table 5. Gender-gaps in employment and earnings in Turkey, 1995

	Distribution in employment (%)		Share in employment (%)		Female earnings as percentage of males'
	Female	Male	Female	Male	
Scientific and technical professionals	6	5	31	69	54
Managers and Executive	1	2	6	94	80
Services	4	22	12	88	56
Agriculture	72	33	50	50	37
Manufacturing	12	34	14	86	50

Source : UNDP (1996) and Dayioglu, M. (1996)a

Box 2. Economic opportunities and political positions are still monopolised by men

In a country like India, women managers and executives account for only 3% of total managers and executives. Women also carry the larger burden of housework and they constitute the largest share of unpaid workers. In Nepal, women do 63% of unpaid work, compared to 24% by men.

The situation becomes worse as one moves into the political arena. In none of the six countries does female representation in parliament reach even 20% – the highest being 18% in Botswana. But it drops as low as 3% in Nepal. In local governments, too, women are represented poorly – 1% of local level councillors in Turkey are women. None of the 13 regional governors in Namibia is a woman and all 100 Mayors and Deputy Mayors in Nepal are men. The height of the disparity, however, is exemplified by Botswana's Gender Councils, whose mandate is to ensure gender equality in all walks of life. Nearly 90% members of these Councils are men.

Source : Nepal South Asia Centre (1998), Shariff, Abusaleh (1999), UNDP with UN Country Team (1998) and UNDP (1996)

In addition, the representation of women in professional and technical jobs and in executive and managerial positions is low in all countries and extremely marked in the political arena (see Box 2).

Gender-disaggregated data on income poverty is sketchy in most situations, with data available only for three countries: Botswana, Cambodia, and India. In Botswana and India, more women or female-headed households have been found to experience greater income poverty than their male-headed counterparts – in India in 1996, 43% of women compared to 39% of men. However, in 1997, Cambodia showed a reverse trend — 33%, compared to 37% among male-headed households, an exception to the general picture that may stem from the Khmer Rouge kinship structure, which gives women equality with men in many areas.

In the absence of gender-disaggregated data on income poverty, analysis in terms of an association of relevant outcomes has been pursued, establishing the possibility of higher incidence of income poverty among women in relevant instances. For example, income poverty in general is observed to be higher among people who are illiterate and engaged in agriculture. At the same time, it is women who are more illiterate and who are mostly engaged in agriculture. By association, then, women are more likely to be income-poor than men. Data from Nepal highlight such an association (see Table 6). Moreover, when impoverishment among women, as well as between men and women, is analysed in terms of data further disaggregated within a distributional perspective, other trends become manifest.

Table 6. Possibility of higher incidence of income poverty among women through association in Nepal, 1996

	People below the national poverty line (%), 1996
Illiterate	51
Self-employment in agriculture	55
Wage employment outside agriculture	35
	Female
Illiteracy for persons over 6 years (%)	79
Self-employment in agriculture (%)	83
Wage employment outside agriculture (%)	4

Source : Government of Nepal (1997a)

Women cannot be treated as a homogeneous group. Visible differences in health and education and income poverty outcomes emerge according to class or location specificity in all six countries. Women belonging to the richest class, urban women, and women living in developed regions are better off than the poorest, and those who live in the rural and less developed regions respectively. The latter are also doubly deprived, first because of the general impoverishment of their situations and secondly, because they are women. Cambodia presents an illustrative case in terms of health and education outcomes, as Table 5 indicates. In terms of income poverty, examples from Botswana highlight the issue: 57% of female-headed households in rural Botswana were in income poverty in the mid-1990s in contrast to 35% in urban areas. Human development outcomes may also be differentiated among women in terms of caste (see Table 7).

Table 7. India – Differentiated human development outcomes among women along caste lines, 1996

	Scheduled caste	Muslims	Hindus
Female literacy rate (%)	28	38	39
Females completing secondary level (%)	2	3	5
Female primary net enrolment rate (%)	55	57	65
Female discontinuation rate (%)	9	7	8

Source : Shariff, Abusaleh (1999)

Association analysis also indicates the vulnerability of women in rural or least developed areas to fall into income poverty. As Table 8 shows, in Nepal, across the country's topographical regions, women have a smaller share of income-earning jobs and lower literacy rates. These shrink their opportunities compared to men and thus make them, in general, more susceptible to impoverishment. But women in the Mountain region may be the hardest hit; overall income poverty is worst in the Mountain regions, which is also the region where only 13% of women have income-earning jobs (the lowest in Nepal). In addition, the 87% female illiteracy rate of the Mountains is the highest in the country. Thus women from the Mountain regions may have the fewest opportunities to avoid income poverty.

Table 8. Possibility of higher incidence of income poverty among women in the Mountains of Nepal, 1996

	Mountains	Tarai	Hill
People below national poverty line (%)	63	50	37
Female literacy rate over 6 years (%)	13	20	31
Income earning jobs held by women (%)	17	39	51

Source : Government of Nepal (1997a)

There is also a strong linkage between access to inputs for each group and the outcomes of their lives. The lower life expectancy and higher mortality rate among poorer women can be associated with lesser access of this group to health services or safe water (see Table 9).

Table 9: Linkage between access to input and outcomes by richer and poorer women in Cambodia, 1997

	Bottom quintile	Middle quintile	Top quintile
Female life expectancy at birth (years)	57	60	63
Women not expected to survive age 40 (%)	30	27	24
Women with access to health services (%)	56	69	75
Women with access to safe water	29	38	56

Source: Kingdom of Cambodia, 19967

In India, the higher incidence of income poverty among rural female-maintained households (46%) compared to urban ones (37%) may be linked to the lower access to credit by female-maintained households in rural areas (26%) compared to their urban counterparts (53%). There are sharp differences in amounts of average loans received – 3000 Rupees for rural compared to 8,882 Rupees for urban households. Moreover, outcomes in different areas mutually reinforce each other. For example, the female literacy rate in rural areas is worse than that in urban areas because the

enrolment and school attendance rates are worse among women in rural areas compared to those in urban areas. This is also true along caste lines, as Table 5 indicates for India.

However, women are not always worse off than men. Income class, location specificity and caste and ethnicity all play crucial roles. In general, women belonging to the richest class are better off than than men in the poorest class. The same is true of urban women compared to rural men or women in developed regions compared to men in less developed regions. This has been manifested in health and educational outcomes. In Namibia, girls belonging to the top income class or living in Khomas, the most developed region of the country, have better health and educational outcomes than boys in similar situations. This is true of other comparable income classes or regions (see Table 10).

Table 10. Health and educational outcomes in Namibia in 1996 : women are not necessarily worse off

	Female Bottom quintile	Male Middle quintile
Infant mortality rate (per 1,000 live births)	57	42
Children (under 5 years) stunted (%)	36	29
Children underweight (moderate %)	35	29

	Female Khomas	Male Oshana
Life expectancy at birth (years)	69	64
Infant mortality rate (per 1,000 live births)	38	56
Adult literacy (%)	82	68
School enrolment (%)	91	84

Source : Gwatkin, Davidson R. (2000); UNDP with UN Country Team (1998) and Government of Namibia (1998c and 1998d)

The same conclusion is borne out in the area of income poverty in Botswana. In 1994, while 35% of female-headed households in urban Botswana lived in income poverty, the corresponding figure for male-headed households in rural areas was 55%. The relative condition of men and boys is not always explained by their sex; their income, class, and location specificity also play important roles.

HIV/AIDS

Gender-disaggregated data on overall incidence of HIV/AIDS were available for all countries except Turkey. Of the five other countries, in Botswana and Namibia, where the pandemic is a serious developmental and health problem, women bear a larger burden of HIV/AIDS, as Table 11 shows in Botswana in two respects. First, the direct incidence of HIV/AIDS is higher among women and secondly, they must also care for other infected family-members. In Botswana, too, girls are more susceptible to HIV infection than boys – for every HIV-positive boy under age 14, there are two HIV- positive girls in the same age group.

Table 11 : The incidence of HIV/AIDS and the unequal burden for women – the case of Botswana

	Female	Male
Number of people (15-49) years living with HIV/AIDS, end of 1999	145, 000	125,000
People in age group 15-24 living with HIV/AIDS, end of 1999	34	16
Deaths of secondary school teachers (25-34) in percentage, end of 1999	22	8
Projected adult (age 15-49) mortality rates per 1,000 in 2010 because of HIV/AIDS	33	24

Source : Government of Botswana and UNDP (2000)

It is estimated that the future adverse impact of HIV/AIDS will also be greater for women. For example, by 2010, women in Namibia will lose 11 years in terms of life expectancy, while the comparable loss for men will be 8 years.

"Gender –Neutral" Policy Frameworks

Given the view of women in most societies as inferior to men and inherently subordinate to them, gender equality is more rhetoric than reality in most social contexts. The persistence of stereotypes conditions women's work, their employment, the valuation of their contributions, their legal status and their representation in public life. It also leads to failures at the country level to "engender" development strategies – on the assumption that policy is gender-neutral. In Turkey, for example, policies to enhance female participation rates have concentrated only on higher wage rates. But the female labour market participation rate is also a function of the division of women's time between productive and reproductive roles, an issue not considered in the policy framework. Similarly, policies on HIV/AIDS need to be linked to violence against women, including rape, prostitution and trafficking. Yet neither Botswana nor Cambodia, where such problems predominate, has taken them into account in efforts to curb the pandemic.

A review of the policy framework in the six country case studies highlights the following trends:

- Though their constitutions and the legal frameworks proclaim equal rights for women, most of the laws that explicitly support this principle are not implemented and the general legal structure remains biased. Women experience discrimination in inheritance laws, in access to jobs, and pay rates, even in countries, such as Cambodia and India, where all the requisite laws exist. Similarly, though all the countries have ratified the Convention on the Elimination of All Forms of Discrimination against Women, each falls short of implementing its various clauses.

- Most of the six countries lack gender-sensitive health policies, whether in access to general care or services in reproductive health, even in pre- and ante-natal care for children, particularly in least-developed regions, where they are most needed. Overall, health policies ignore women's specific needs.

- Despite higher academic achievement by girls at all educational levels (see Box 3), national policies not only fail to explain this performance, but overlook specific problems faced by girls – among these, the availability of schools within manageable distance from home, particularly at secondary level.

- Gender differences in educational attainment affect inequalities that women face in other areas, as Table 5 shows for Turkey. Yet the policies of most countries pay no attention to this crucial correlation, whether in the education, health or labour/employment sectors. Nor do most countries have effective affirmative programmes to promote the participation and advancement of women even in public sector jobs.

Box 3. Women are doing better in education

In Botswana, the female adult literacy rate at 70% is higher than that of male literacy rate at 67%. The net primary and secondary enrolment rate among girls is 72% compared to 69% for boys. While 31% of female students finish Grade 5, only 29% boys do that. In Cambodia, the drop-out rates for girls at Grade 12 is 26%, less than the 29% for boys. In Turkey, at the tertiary level, among new entrants, there are 114 women in medical science compared to 100 men and among the graduates there are 234 women vis-à-vis 100 men. In Engineering, 50% of the graduates are women.

Source : Government of Botswana and UNDP (1997), Kingdom of Cambodia and UNDP (1998) and UNDP (1996)
Source : Government of Turkey (1996b) and Dayioglu, M. (1996).

In the majority of cases, NGOs and the institutions of civil society have moved the policy agenda for women and for gender equality forward. Public policies have either reacted or followed — or in many instances have remained static. Botswana is a classic example. And in most cases, gender-disaggregated data either do not exist or fall far short of the requirement for formulating policy.

Non-Disaggregation of Data by Gender

Because of a number of recent initiatives at the global level, gender data collection has improved. Reports like the United Nations' The World's Women, UNIFEM studies and the World Bank's Report on Engendering Development have mobilised greater disaggregation efforts. Publications by the regional economic commissions have also contributed to this process. But the most significant contribution at every level has come from UNDP's Human Development Reports (HDRs). By introducing the Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM) in 1995, the global HDR has induced a process of gender-disaggregated data in life expectancy, educational attainment, income shares, and representation in technical and professional jobs, as well as in executive and managerial positions, and political participation. That tradition has been taken up by regional HDRs and the National Human Development Reports (NHDRs). As a result, gender-disaggregated data are available for many more countries than was the case early in the 1990s.

Nonetheless, for the six countries presented here, the following general shortcomings emerge:

- Although overall gender-specific data are available in the health and education sectors, they are scarce with regard to economic participation, economic benefits (wages and earnings) and political participation. On the issue of access to productive resources (land, livestock and credit), except in India, there are no data at all, let alone gender-specific figures.

- Even though HIV/AIDS is the greatest development challenge in Botswana, Cambodia and Namibia with major implications for women, most data on key aspects of the pandemic are not gender-disaggregated.

- Further disaggregation of gender data in terms of income class, location specificity and ethnic background may be available for some health and education indicators, but not in other areas of human development.

- In some cases, development data disaggregated by caste (Nepal) and by language groups (Namibia), are available. They could have been more useful had they been disaggregated by gender as well.

Achieving the MDGs

These shortcomings, in turn, reveal a number of actions required by each to meet the MDGs. With regard to achieving the MDGs in general and the goal of gender equality in particular, the country case reviews show that different countries are on

different tracks. An assessment of their respective situations and synthesising the results indicate the following :

- In terms of gender equality in education, Botswana and Turkey have already achieved it in primary and secondary enrolment. In Botswana's case, what is needed is a to further increase the enrolment ratios for both girls and boys. Namibia is very close to achieving it, Cambodia may be on track, and India and Nepal still face significant gaps.

- In areas like halving extreme poverty and hunger, reducing infant and child mortality by two-thirds or reducing the maternal mortality rate by three-quarters, most of the countries — Botswana, Cambodia and Namibia — will have to cover a lot of ground during the next 15 years. Since income poverty in Botswana and Namibia is higher among women, they need to focus more on women's income deprivation. Similarly, given the greater impact of HIV/AIDS on women, both Botswana and Namibia should devote greater efforts to the problem in all its dimensions.

- Turkey seems to be on its way to achieving most of the goals. Its record in reducing income poverty as well as infant and child mortality is strong and it is almost within reach of the MDGs in the areas of both hunger and safe water.

- The situation in Nepal indicates that the country is not on track in achieving the MDGs. Since women are most affected in terms of mortality and income poverty, moving towards all the goals requires greater attention to gender disparities.

- India, with its highly diversified population of more than one billion people, faces huge development challenges. Although the country is on the right track, accelerating progress calls for concentrated efforts on women.

Expanding the Database

The review of these six countries indicates some of the ways for increasing the collection of gender-disaggregated data in areas of human development:

- By consciously engendering the questionnaires of censuses and surveys by adding a few queries in the present set of questions;

- By changing the sample to cover more women in each population;

- By interviewing women of households during household expenditure surveys or labour force surveys;

- By having more female investigators and enumerators;
- By taking gender as the theme of more NHDRs.

Enriching the Development Paradigm

What does all the foregoing analysis tell us about policy formulation, certainly at the national level?

- First, we need to know far more about differences in poverty among women themselves.
- Second, to this end, we must look beyond obvious forms of gender discrimination and analyse the complex socioeconomic realities — such as class, ethnicity and geographic location — to the disparities that exist between men and women.
- Third, we must identify the interplay between determinants and outcomes, notably the ways in which they reinforce each other.
- Fourth, we need to use these kinds of data to assess the gender impacts of human development policies, inter alia for benchmarks to monitor progress.
- Fifth, we need to incorporate such gender-specific data into planning frameworks at the national level, notably the Common Country Assessments (CCAs) and the Poverty Reduction Strategy Papers (PRSPs), which currently lack the gender dimension.
- Finally, we need to undertake a comprehensive engendering of the development paradigm. This will require revisiting a great number of the analytical and empirical issues discussed in this essay itself, along with many of our tacit assumptions about human well-being.

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