Sorry State of Women's Health

❍ **Diksha Rajvanshi**

Among the chief causes of high female mortality are female foeticide and female infanticide, as well as a conscious neglect of the health and nutritional needs of females from birth to adolescence to youth. Early marriage, unsafe motherhood, lack of medical attendance at childbirth, and poor health and development infrastructure are othe causes. Illiteracy and discriminatory socio-cultural values, attitudes, beliefs, and practices further compound the already precarious condition of females, especially in the large parts of rural India where three quarters of the population live.

The child sex ratio for children 0 to 6 years of age shows a highly negative trend that is also a cause for serious concern.

Child Sex Ratio (0-6 yrs) 1981–2001	
1981	962
1991	945
2001	927
Source: Census of India 2001	

During the past decade, advances in human reproductive technology have revolutionized medical science. Sex Determination Tests (SDTs) have become prevalent. These tests were originally devised to detect any genetic abnormalities in the developing foetus, so that the birth of a potentially handicapped child could be averted. Practically, however, SDTs are done to know the sex of the unborn child. If it is a female, abortion is the usual outcome.

Fewer women than men tend to report their illnesses, not only owing to differences in social perceptions of them and their social obligations which leave little time to go to public health facilities but also because many government-financed public health services often view women as targets for sterilization under the family welfare programme. This becomes a reason to avoid the use of such facilities for those who do not want to be pressured into this operation. Other major reasons cited for not seeking treatment include financial problems and lack of availability of health facilities.

Poor nutrition status hampers a woman's capacity to work as well as her productivity. It increases her susceptibility to infections, and contributes to numerous debilitating and fatal conditions. The chief cause of malnutrition is mostly a lack of income to purchase adequate food, but also often includes an inequitable distribution of food within the household, improper food storage and preparation, and lack of knowledge about nutritious foods. Malnourished women are more likely to give birth to low birth-weight babies, and if the underweight baby is a girl who survives pregnancy and infancy, she is likely to continue to be under nourished throughout childhood, adolescence, and adult-life. Inadequate nutritional intake is closely linked to the relatively higher rates of female morbidity and mortality.

The National Family Health Survey of 1998–99 states that 52 percent of married women aged 15–49 years and 74 percent of their children below three years of age suffer from anaemia. Nutritional anaemia is widespread among women and contributes significantly to maternal morbidity and mortality. Women need three times more iron than men because of the physiological requirements of menstruation and pregnancy. Iron-deficiency anaemia in pregnancy is an important cause of maternal morbidity and mortality. Anaemia during pregnancy can also result in intrauterine growth retardation, low – birth-weight babies, and poor lactation. Iron-vitamin supplements are inexpensive and easily administered, but are just not made available for many poor women who suffer terrible weakness as a result. Anaemia has a profound effect on a woman's health, as it lowers her resistance to fatigue and disease, and affects her working capacity. It greatly increases the risk of ill-health and death in child birth. Anaemia not only depletes her physical resistance to disease but also results in the retardation of a woman's physical growth and development.

The reproductive health of a woman shapes the quality of each day of her life.

Government health policies and programmes have never accorded intrinsic importance to women's health. Their health was mostly considered, if at all, only when there was some external justification for providing health care to them. Attention to women's health issues has either been uterocentric or gender blind. It has mainly addressed fertility rates. After 55 years of planned development, no comprehensive health policy has addressed the issue of women's health in an integrated manner.

Control over the reproductive function of women for national policy purposes has always been the central priority of government health expenditures for women, mostly through the Family Planning Programme (FPP). Even now, instead of focusing on the overall health problems of women as a specially disadvantaged group, government policies continue to stress health policies as they relate to State control over women's fertility. State policy spelt out in the Family Planning Programme (FPP), the Health and Family Welfare Programme (HFW), the

Integrated Maternal and Child Health (MCH) scheme, the Child Survival and Safe Motherhood (CSSM) Project, and, finally, in the Reproductive and Child Health (RCH) approach in the Ninth Plan continues to target women primarily in order to meet fertility reduction targets.

Societal Barriers

Girls are born with certain inherent biological advantages that make them less vulnerable than boys to childhood diseases, if they are only given equal nutrition, health conditions, and health care. Discrimination in the treatment of girls often negates their innate biological advantages. Girls who are fed and nurtured less, given minimal access to health services and education, and denied the skills required for economic autonomy suffer the effects of this devaluation for the rest of their lives. The cumulative effects of illness, deprivation, and malnutrition in childhood can also lead to impaired intellectual development and ill health later in life.

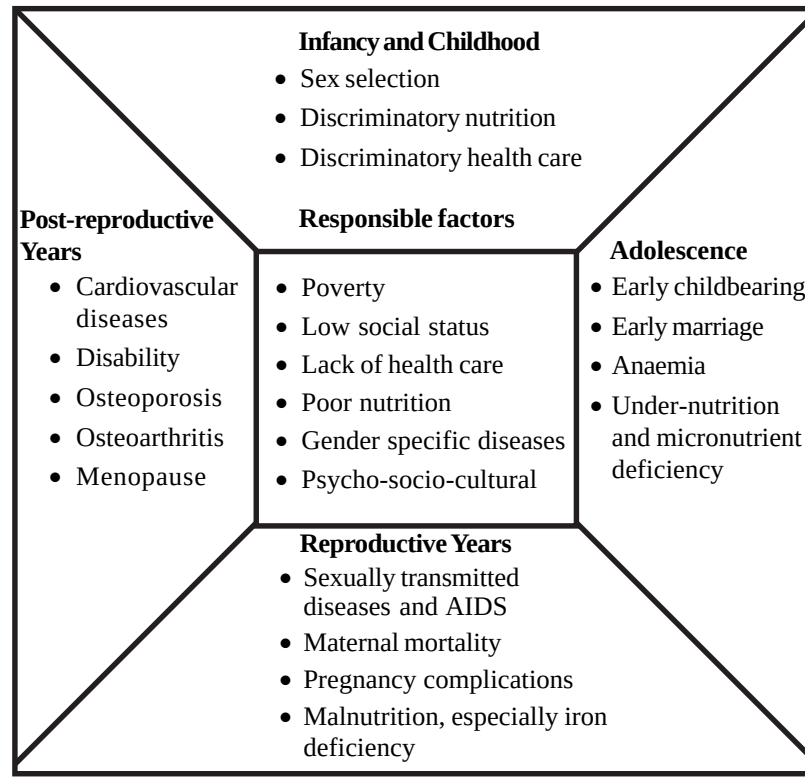
Changes We Require

The positive effects of providing basic health services for women are evident in Kerala which is the only state in India where the gender ratio is comparable to that of European countries and the USA. It is also the state with the highest female literacy rate. Kerala has the lowest birth rate in India, despite having a very high-population density. This confirms what specialists have always indicated—when women are educated, they are more aware of the choices that are before them and their consequences.

However, even in Kerala, we are witnessing a new alarming trend of decline in the sex ratio of baby girls in the 0-6 age group, indicating that the culture of female devaluation is making inroads even among matrilineal communities which did not have such a tradition.

Healthy women make a healthy family and a healthy society. Improving the status of women's health and nutrition is fundamental to the success of all forms of social development. The vicious cycle of malnutrition, anaemic conditions, low birth-weight babies, high neonatal and infant mortality, high maternal mortality, reproductive tract infections, and post-menopausal problems has to be ended by a virtuous circle of awareness, access, and affordability for adequate nutrition and preventive and curative health care. Until women gain access to comprehensive public health care, the slogan of "Health for All" will remain an empty promise. Health is not a commodity. It is not a negotiable good that should be bought and sold for a price or traded off against economic gain. The reduction of inequity, the provision of choices, and the development of health accountability mechanisms are essential components in working toward a decent society that provides basic health security for all.

Health and Nutrition Problems Affecting Women During the Life Cycle



Based on "A New Agenda for Women's Health and Nutrition" World Bank Publication, 1994.

References

The *Tenth Five Year Plan 2002–2007*, Planning Commission. Government of India, New Delhi.

Overview of Trends in Maternal Mortality. Report of a Workshop, Indian Council of Medical Research, New Delhi. 1988.

International Institute for Population Sciences (IIPS). *India National Health Survey 1993–1994*, Bombay. 1995.

Nandraj S., N. Madhiwalla, R. Sinha, and A. Jeswani. *Women and Health Care in Mumbai: A Study of Morbidity, Utilization, and Expenditure on Health Care in the Households of the Metropolis*, Center for Enquiry into Health and Allied Themes, Mumbai. 1998.

Rao M. "Family Planning Programmes: Paradigm Shift In Strategy", *Economic and Political Weekly*. 2000. vol 35 (49): 4317–4322.

Development in Practice: A New Agenda for Women's Health and Nutrition, World Bank Publication, 1994.

The author is a research scholar, Department of Economics, University of Rajasthan. ❑