UNIT 3 HEALTH AND NUTRITION OF RURAL WOMEN

Contents

3.0 OBJECTIVES

A female's health status has a direct bearing on the health and well-being of the whole family. Maternal morbidity and mortality affect not just the mother but the entire family. Most often, women not only shoulder the responsibility of home management and child care, but are also actively involved in economically gainful employment outside the household or even contribute significantly in the family business, be it agriculture or industry. They play dominant role in rural economy. It implies that their health and nutritional status is of paramount importance for their own family as well as, for the nation's development. Poor health condition reduces their ability to take care of the family members and also their earning capacity. After reading this unit, you will be able to:

- understand the concept of nutrition in respect of health of rural women;
- list the key indicators of women's health and nutritional status;
- examine the causes of their low level of health and nutrition;
- socio-cultural factors affecting health and nutrition of rural women,; and
- discuss some of the policy initiatives and ongoing programmes geared towards maternal health.

3.1 INTRODUCTION

The World Health Organisation defines 'Health' as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". It is a utopian concept of health. Practically, we see that health is a dynamic state and most people fall in between the continuum of complete ill-health and perfect health. Nutrition is the pre-requirement of health status. The most widely accepted definition of nutrition, as given by Robinson, is "it is the science of foods, nutrients and other substances, there in, their action, interaction and balance in relation to health and disease, the process by which the organism ingests, digests, absorbs and utilizes nutrients and disposes off their end products". Individuals need a wide range of nutrients to keep them healthy and active.

Health is a basic need and a fundamental right of everyone and it assumes special significance in the case of women. The reasons are many. Firstly, females constitute almost a-half of the total population and more than one-third of the total workforce. Secondly, major responsibility of bearing and rearing children lies with the women. Their health status directly influences the health and well-being of children. An inadequate intake of nutrients could lead to malnutrition and deficiency diseases. Low nutritional status makes women prone to certain ailments. Lower health status manifests itself in lower life expectancy, higher rates of morbidity and mortality, lower levels of productivity, and a decreased ability to earn and support.

From the above discussion, it may be inferred that health and nutrition go hand in hand. Women's health and nutrition have a direct and strong repercussion on health status of the whole family, particularly their offspring. Let us first try to have a better understanding of nutrition viz-a-viz women.

3.2 NUTRITION

Nutrition is a science of nourishing the body. It is the relationship between man and his food, which includes not only physiological and biochemical aspects, but also psychological and social dimensions too. Nutrition is a wide term, which is also concerned with the economic, cultural and psychological implications of food and eating.

Why do we need food? Food performs three main functions of providing energy, repairing the body and maintaining growth and protecting the body against diseases. No single natural food item performs all these functions. We need a variety of foods to meet the nutritional requirements of the body. In order to keep good health, one needs a variety of foods, so that all functions are performed well. Such diet is called a balanced diet. The foods are classified into three major categories depending upon the functions they perform. They are mentioned below:

1) **Foods for Energy**

Foods for energy include cereals like wheat, rice, jowar, maize and bajra; roots and tubers like potatoes, sweet potatoes and tapioca; jaggery and sugar; fats and oils like ghee, vegetable oil, butter and vanaspati. Food for energy is very essential as energy is required for essential body functions, growth and physical activities. It is, therefore, important to include energy giving foods in the daily diets of young children.

2) **Foods for Growth and Maintenance**

Proteins are required for the growth and maintenance of the body. Pregnant females and lactating mothers require additional amounts of protein for the proper growth and development of foetus and infants. All legumes, pulses, peas, beans and nuts are good sources of proteins. Animal sources like milk and milk products, eggs, meat, fish, etc., are rich sources of protein. Cereals also contain proteins, though in smaller amounts.

3) **Foods for Protection Against Diseases**

Certain foods are required for the proper functioning and protection of the body. These foods contain important nutrients like minerals and vitamins. Inadequate intake of vitamins and minerals may lead to a number of deficiency disorders.

A woman needs to have a balanced diet, which includes proper amounts and combinations of all the above mentioned foods to maintain good health, an essential pre-requisite for a good quality of life and growth and development of their children. On the other hand, malnutrition leads to cropping up of a number of deficiency diseases and ailments, which lowers the capacity of women to perform her salient roles efficiently like, child care, home management, earning money, and the like.

3.3 HEALTH AND NUTRITION IN RELATION TO WOMEN

Patriarchal social structure, gender discrimination right from the birth, malnutrition, illiteracy, unskilled labour, hard physical work, early marriage, repeated and multiple pregnancies and poverty are some of the factors that weigh against the rural females. Even after being biologically superior, females have higher rate of morbidity. Females suffer from triple jeopardy. Apart from having nutritional deficiency disorders, they often have gynecological and pregnancy related diseases. Let us look into the factors that influence health and nutritional status of the females.

1) **Gender Bias**

Low sex-ratio is the indication of discrimination against females in our patriarchal society. Gender bias works against females even before they are born. Practice of techniques like amniocentesis or finding the sex of the foetus in the womb, followed by abortions, though illegal, is still rampant. The preference for sons may result in huge families. During the distribution of resources at the household level, priority is given to males, be it nutrition, medical care or opportunity for education, growth and development. Women in poor rural communities are found to seek medical assistance for their sons more frequently and promptly than for their daughters. So, from early childhood, the health status of females becomes low for the lack of proper nutrition.

The socio-cultural milieu is such that women are not expected to bother about their own health. Moreover, women are the last in the family to eat after serving the men, when the quantity of food left over could well be inadequate. This in itself is a reflection of the status accorded to women by the society. The women would try to give best nutritional status to their family, within their limits, but they have learnt to ignore their own nutritional requirements. They are socialized to sacrifice their own needs and desires, including that of proper nutrition, in favour of the male members of the family.

2) **Early Marriage and Repeated Pregnancies**

The adolescence, 14-18 years, is a period of active growth and many physio-sexual and emotional changes for girls. According to National Nutrition Monitoring Bureau data, during this period, on an average, girls gain 6.8 kgs and 5 cm in their weights and heights, respectively. When pushed into marriage and motherhood at an early age, naturally their growth is affected. Anaemia is one of the most widely prevalent deficiency disorder among rural adolescent girls in India. A pregnancy at this stage is a 'high risk' pregnancy. Pregnancy in a physically immature woman and whose growth is stunted leads to complications, such as abnormal presentation and prolonged labour. Medical intervention, badly needed in such cases, is either absent or inaccessible in many parts of rural India. Several studies have shown that mothers whose ages are either below 20 or above 30 years, whose birth intervals are less than 2 years, and who have a parity of above three, (i.e., more than three children) experience high infant mortality and maternal morbidity.

One of the measures of fertility, the Marital Fertility Rate, is expressed as the number of live births per thousand married women in the reproductive age group of 15-45 years. As we have mentioned earlier, according to the National Perspective Plan for Women, the Indian woman, on an average, is pregnant 8-9 times, resulting in around six live births of which finally 4-5 survive. She spends an estimated 80 per cent of her reproductive years in pregnancy and lactation.

During pregnancy and lactation period, the females are expected to have additional intake of calories, protein and other essential nutrients for the proper growth and development of the child and for her own health status. However, ignorance, along with poverty, often leads to inadequate dietary intake during the periods of pregnancy and lactation. This results in low health status, gynaecological and obstetrics related ailments among the mothers. Low and inadequate nutritional status among females often results in high rates of infant mortality rates and maternal mortality.

3) Quality of Antenatal Care

Antenatal care can go a long way in reducing maternal morbidity and mortality, as it can identify risk factors and accordingly provide for remedial action. Even a minimum of three antenatal check-ups by trained health personnel is enough to identify risk factors. Certain conditions like age – below 18 years and above 35 years, height below 145 cms, first pregnancy or a pregnancy after more than four children, anaemia, blood pressure, poor obstetrical history, abortions, stillbirth, multiple pregnancy, etc. often contribute to high maternal morbidity and maternal mortality rates.

Added to this, the quality and delivery of antenatal services leave much to be desired. In spite of a vast web of Primary Health Care, in most cases, the antenatal services reach to the rural expectant mothers only towards the second half of the pregnancy. During the critical period, the first trimester often remains medically unattended. Many studies have shown that very few pregnant women get themselves registered at the Health Centre or get regular check-ups done by trained health practitioners. They do not regularly take iron and folic acid tablets or tetanus toxoid injections. This adds up to the chances of complications during the pre-natal and ante-natal period. Most often, rural women do not avail of pre-natal and ante-natal medical care even if they can easily do so. The reasons may be attributed to lack of awareness or apathy towards their own health status.

Table 3.1: State-wise Distribution of Neonatal Mortality Rate, Infant Mortality Rate and Percentage of Expectant Mothers who received Ante-natal Care

States/UTs	Neo-natal Mortality Rate	Infant Mortality Rate	% of Mothers Received ANC
Andhra Pradesh	43.8	65.8	92.7
Assam	44.6	69.5	59.8
Bihar	46.5	73.0	36.0
Chhatisgarh	66.4	90.6	57.5
Gujarat	39.6	62.6	86.3
Haryana	34.9	56.8	58.0
Jharkhand	36.6	54.3	41.7
Karnataka	37.1	51.5	86.3
Kerala	13.8	16.3	98.9

Madhya Pradesh	54.9	86.1	61.1
Maharashtra	32.0	43.7	90.0
Orissa	48.6	81.0	79.2
Punjab	34.3	57.1	74.1
Rajasthan	49.5	80.4	47.2
Tamil Nadu	34.8	48.2	98.4
Uttar Pradesh	53.6	86.7	34.3
West Bengal	31.9	48.7	89.5
Arunachal Pradesh	41.8	63.1	60.9
Delhi	29.5	46.8	83.2
Goa	31.2	36.7	99.0
Himachal Pradesh	22.1	34.4	86.8
Jammu & Kashmir	40.3	65.0	83.0
Manipur	18.6	37.0	80.1
Meghalaya	50.7	89.0	53.1
Mizoram	18.8	37.0	90.3
Nagaland	20.1	42.1	59.4
Sikkim	26.3	44.0	70.0
Tripura	28.6	44.2	70.9
Uttaranchal	25.7	37.6	43.4
India	**43.4**	**67.6**	**65.3**

Source: National Family Health Survey, 1998-99.

Table 3.1 above clearly indicates that there is a direct relation between the expectant mothers receiving ante-natal care and neonatal and infant mortality rates. For example, in places like Goa and Delhi, most often, expectant mothers receive ante-natal care and there neonatal mortality rate is quite low. Chhatisgarh state is having the highest rate of neo-natal mortality rate, though almost 57 per cent females are getting ante-natal care. This brings into focus the question of quality of services provided by PHCs and their sub-centres. So, there is a need for improvement in the health care services provided along with their expansion to the remote rural areas.

4) Lack of Awareness

Low levels of literacy and lack of awareness regarding health and nutrition are important causes of the prevailing health situation. The census data of 2001 show that 52.21 per cent of the total Indian population is literate out of which only 39.3 per cent females are literate. Coming specifically to the rural literacy rate, 44.7 per cent are the total literate of whom 30.6 per cent are females. Kerala has the highest female literacy rate, while Rajasthan tops in number of illiterate females. The direct relation between literacy and awareness level is a well-known fact.

Poverty as well as ignorance contribute to under-nutrition and malnutrition among many rural women. Many times women and children suffer from malnutrition not because of lack of money or foods, but due to ignorance about the right kind of foods needed for the proper growth and functioning of the body. Therefore, creating awareness about the nutrition and health is an important task especially in the rural

areas. Integrated Child Development Services, as one of its components, offers Nutrition and Health Education to females in the age group of 15 to 45 years. However, the actual implementation and the quality of the NHE is a big question mark.

One of the adverse impacts of lack of awareness on issues related to women's health and nutrition is the teen-age pregnancies. In rural areas, teenage pregnancy appears to be the rule rather than the exception. We see the strange phenomena that millions of girls in the age-group of 14 to 18 years are compelled to engage in child bearing and child rearing even before they have had a chance to complete their own physical growth and development to attain adulthood. The National Nutrition Monitoring Bureau (NNMB) surveys show that the average intake of calories is substantially below the recommended dietary allowance (RDA) for men and women, especially in the case of adolescent girls, pregnant and lactating mothers. Some of the findings of the District Nutrition Surveys conducted in 187 districts in 18 Union Territories related to nutrition intake are as under.

- Intake of green leafy vegetables was found to be inadequate in most states, except those in the hill states.
- The consumption of milk and milk products per consumption unit was inadequate in almost all the districts of India excepting those belonging to the northern region and Gujarat.
- Intake of oils was found to be inadequate in most districts of India, especially those belonging to north eastern and southern regions.

3.4 INDICATORS OF HEALTH AND NUTRITIONAL STATUS

Health Indicators

Life expectancy and mortality rates are the most commonly used indicators of the health status of a population, in the absence of suitable measurements that can adequately capture the holistic meaning of health as defined by WHO. In this subsection, let us try to understand some of the key macro indicators of the health status of women.

1) Life Expectancy

Life expectancy at birth is a hypothetical measure expressing the average number of years a newborn can be expected to live if the current mortality trends continue. It indicates the current health and mortality conditions in a population. Life expectancy of women can be taken as an indicator of their health status. Life expectancy for women in general has shown an increase from 44.7 percent in 1971 to 64.0 in the year 2001. Life expectancy at birth has improved for both men and women in India during the century from a low of 23 years to 64.0 years in 2001. While the improvement in life expectancy for the first 50 years was only by 10 years, the increase has been more than double by another 20 years in the latter half of the century, owing to improvements in nutritional intake, health infrastructure, access and knowledge of medicine.

While life expectancy has increased for both males and females, there is not much evidence of substantial improvement in the health and nutritional status of women. Apart from demographic indicators, health indices, such as morbidity rates, nutritional status, quantity and quality of food consumption data indicate women's inferior status.

2) Sex Ratio in the Population

Sex ratio is a sensitive indicator of the status of women in any society. Decline in the sex ratio in India over the century from 972 in 1901 to 929 in 1991 and then to 933 in 2001 is great cause for concern. There are socio-cultural factors associated with declining sex ratios, which vary significantly in different parts of the country. The lowest sex ratio is in the state of Haryana with 865 females per 1000 males against 1040 females per 1000 males in the state of Kerala. It is also important to recognize that the development programmes in the states having lower sex ratio than the national average, have not reached the women nor ensured their survival. Kerala is the only state that has consistently shown a higher proportion of females and a sex ratio of more than 1000 since 1971. The reason for this is the provision of access to opportunities for survival and development of girls. The table below gives the comparative view of sex ratio of 1991 and 2001. It shows that sex ratio is highest in Kerala, the reason for which may be attributed to the socio-cultural milieu and high female literacy rate. Haryana ranks the lowest in the sex ratio due to adverse socio-cultural factors against females. The reason of low sex ratio in cities like Delhi or in Andaman Nicobar may be attributed to high rate of migration and immigration of males in search of work and not due to socio-cultural factors.

Table 3.2: Sex Ratio (Females per 1000 Males)

Sl. No.	India/States/Union Territories	1991	2001
	INDIA	927	933
1.	Jammu and Kashmir	896	900
2.	Himachal Pradesh	976	970
3.	Punjab	882	874
4.	Chandigarh	790	773
5.	Uttaranchal	936	964
6.	Haryana	865	861
7.	Delhi	827	821
8.	Rajasthan	910	922
9.	Uttar Pradesh	876	898
10.	Bihar	907	921
11.	Sikkim	878	875
12.	Arunachal Pradesh	859	901
13.	Nagaland	886	909
14.	Manipur	958	978
15.	Mizoram	921	938
16.	Tripura	945	950
17.	Meghalaya	955	975
18.	Assam	923	932
19.	West Bengal	917	934
20.	Jharkhand	922	941
21.	Orissa	971	972
22.	Chhatisgarh	985	990

23.	Madhya Pradesh	912	920
24.	Gujarat	934	921
25.	Daman & Diu	969	709
26.	Dadra & Nagar Haveli	952	811
27.	Maharashtra	934	922
28.	Andhra Pradesh	972	978
29.	Karnataka	960	964
30.	Goa	967	960
31.	Lakshadweep	943	947
32.	Kerala	1036	1058
33.	Tamil Nadu	974	986
34.	Pondicherry	979	1001
35.	Andaman & Nicobar Islands*	818	846

Source: Census of India, 2001

3) **Low Weight and Height**

A majority of young women belonging to the lower socio-economic group are undernourished. According to National Nutrition Monitoring Bureau (NNMB) (1991) data, nearly 24 per cent of adult women in the reproductive period have body weights less than 38 kg, and about 16 per cent have heights less than 145 cm. Girls approach adolescence without meeting the proper nutritional requirements. This does not allow them to achieve their optimum growth. Malnutrition results in stunted growth and affects the proper development of the pelvis. When a girl reaches puberty, she has around four per cent of height still to be gained and 12-18 per cent pelvic growth ahead of her (WHO, 1990). Early marriage and teenage pregnancy further interfere in her growth and development. It is, thus, easy to see how these women fall into the 'high risk' category – they are more likely to suffer obstetric complications and give birth to infants of low birth weight (LBW), adding to the risks of increased infant mortality and morbidity.

4) **Anaemia**

Anaemia is one of the most widely spread deficiency disease among women. Anaemia occurs due to deficiency of iron and folic acid. Iron is needed for the formation of haemoglobin that is the carrier of oxygen in our blood. Females are more prone to anaemia due to loss of blood and iron every month during menstruation. Anaemia is characterized by shortness of breath, fatigue, pale colour of eyes and nails and reduced capacity to work. During adolescence, most Indian females run the risk of having anaemia not only due to this biological loss but also this depletion doesn't get covered through adequate diet having sufficient iron.

4) **Maternal Mortality**

Over 100,000 women in the country die annually from pregnancy and stillbirth related causes, thus accounting for about one quarter of maternal deaths world wide. Data of 2001 census show that, in India, maternal mortality ratio is 407 per 100,000 live births. The major causes of these deaths have been identified as hemorrhage (both ante-natal and post-natal), toxemia, (hypertension during pregnancy) anaemia, obstructed labour, puerperal sepsis (infections after delivery) and unsafe abortion.

The main factors for high maternal mortality are unregulated fertility, inadequate

ante-natal care and lack of trained attendant at birth. These are the direct causes of maternal mortality. Maternal mortality is indirectly related to the low status of women and the socio-cultural-beliefs which discriminate against women.

According to the National Perspective Plan for Women, the Indian woman has an average of 8-9 pregnancies resulting in around six births. One of the causative factors of maternal mortality is abortion. The Medical Termination of Pregnancy Act (1971) legalized abortion in India as a health measure. Prior to this, women were at the mercy of quacks who had neither the know-how nor the necessary facilities for carrying out abortions. However, even now most rural women do not utilize the MTP facilities either because they are unaware that it has been legalized or have no access to the facilities or due to social taboos associated with it.

The major causes of maternal mortality are as under:

1)	Toxemia	8%
2)	Abortion	9%
3)	Obstructed labour	10%
4)	Sepsis	16%
5)	Anaemia	19%
6)	Hemorrhage	29%
7)	Others	9%

In order to measure the nutritional status, we take help of certain indicators like weight, height and body mass index. The analysis of the nutritional status of the people of India shows that malnutrition is rampant owing to inadequate energy intake. This is particularly true in the case of women. The major indicators of nutritional status are:

a) Birth weight.

b) Anthropometry

c) Height

d) Body mass index

Let us now analyze each of these indicators in somewhat more detail.

Birth Weight

The average birth weight of the newborns of a particular region or a particular group serves as an important indicator of health and well-being. The birth-weight of newborns is directly related to the health and nutritional status of their mothers. Healthy women give birth to healthy babies. In India, the mean birth weight of babies born to mothers in the higher socio-economic groups is 3.2 kg, which is at par with the mean birth weight in the developed countries. However, the mean birth weight in the low socio-economic group continues to be 2.7 kg. The birth weight of less than 2.5 kg is considered as low birth weight (LBW) and is, thus, associated with higher perinatal, neo-natal and infant mortality. One third of all the infants born in India are low birth weighing babies as against $1/5^{th}$ in the rest of Asia.

Anthropometry

The weights of adults and children are very important in assessing the nutritional status of the population. The accepted fact is that low weight of Indian women is due to shorter height. A significant number of women who are underweight and anemic fail to put on even the average 9 kg to 10 kg during pregnancy. The weight gain during the said period being between 3 to 4 kg. This obviously leads to the birth of low birth weight baby.

Height

Stunted height represents malnutrition during the childhood and adolescence. At the age of five years, there is a deficit of stature of about 8 to 9 cms in both girls and boys when compared to NCHS standards. A 20 year profile of 1977-1997 NNNB data shows that stunting continues to be a problem in both girls and boys. At the age of 20 years, the deficit in height ranges between 12 to 1 cms in case of women and men when compared to NCHS standards. Studies on the heights of the parents and adult children around NIN show an absence of increase in heights of younger generation.

Anaemia

Anaemia is the most common nutritional deficiency seen among the Indian women. The most common cause of anaemia is the deficiency of iron and, to lesser extent, folic acid. Iron is required essentially for the formulation of hemoglobin, which is the carrier of oxygen in our blood. Anaemia is common in India among women who are not pregnant particularly those from the lower socio-economic groups.

As a matter of fact, women have a higher need of iron than men and, consequently, are more affected when the diet is deficient in this nutrient. Anaemia is characterized by shortness of breath, pale colour of eyes and nails and reduction in capacity to work. Pregnancy is a period of nutritional stress and as pregnancy advances, the hemoglobin levels fall in majority of women. Repeated pregnancies also have an effect on hemoglobin levels.

An estimated 50-60 per cent of girls and women in rural areas are anaemic. Loss of blood during menstruation and inadequate dietary replenishment of iron are mainly responsible for anaemia. This condition is worsened by repeated pregnancies. Among pregnant women, the incidence is widespread. 40 per cent of all maternal deaths in rural areas are due to bleeding during pregnancy and puerperium, and anaemia (RGI). While the former is a direct obstetric cause, the latter contributes to the mortality indirectly, but reflects the serious consequences of poor nutritional and health status of the Indian women. In rural India, the contribution of anaemia to all maternal deaths has ranged from 17 to 24 per cent since 1981 (RGI various years).

Table 3.3: Specific Causes of Maternal Mortality by Age Groups Rural India 1988 to 1994

	1988				1994			
Specific causes of maternal mortality	**15-24**	**25-34**	**35-44**	**45-54**	**15-24**	**25-34**	**35-44**	**45-54**
Bleeding during pregnancy and puerperium	35.7	55.4	8.9	0	40.2	44.6	15.2	0
Anaemia	32.3	41.9	25.8	0	46.7	44	9.3	0
Abortion	22.2	66.7	11.1	0	59.2	38.8	2	0
Puerperal sepsis	57.9	26.3	15.8	0	39	41.5	19.5	0
Malposition of child	66.7	20	13.3	0	24	64	12	0
Toxaemia	26.76	46.7	26.7	0	31.4	66.7	2	0

Source: RGI 1990, 1997

Surveys carried out in various parts of the country indicate that 40-70 per cent of pregnant women are anaemic. The mother's reserves of iron and folic acid, already low, are further depleted by repeated pregnancies and lactation, and lack of dietary supplementation. Severe anaemia in pregnancy is particularly dangerous, as it increases, the chances of maternal morbidity and of delivering LBW babies. Maternal mortality is five times higher in anaemic women (WHO, 1990).

Check Your Progress I

Note: a) Write True or False in the space provided for the following statements.

b) If the statement is false, then write the correct statement in its place.

1) A child's health and nutrition is not determined to any great extent by that of the mother.
2) About one quarter of the women in the reproductive age group have body weights less than 38 kg and heights less than 145 cm.
3) The life-expectancy of women in the period 1976-80 was 47.1.
4) Most-often, the direct cause of maternal morbidity is haemorrhage.
5) The symptoms of anaemia are weakness, shortness of breath, pale colour of eyes and nails and reduction in capacity to work.

3.6 POLICIES AND PROGRAMMES

National Nutrition Policy

The national nutrition policy recognizes poverty as a major cause of undernutrition causing a vicious cycle of impaired productivity perpetuating poverty. The need for nutritional policy was recognized, as it was of paramount importance to development. The interdependence of agriculture, food and nutrition systems and the factors associated need to be looked in a wider perspective. The policy states that "it is both possible as well as necessary to devise policy interventions for influencing the working of these sets, thereby improving the nutritional status of the society. It is well recognized fact that increased food production does not by itself ensures nutrition for all. Mere economic development, or even the adequacy of food at household levels, are no guarantee for a stable and satisfactory nutritional status". The policy further states, "therefore, the task is not merely in terms of formulating a nutrition policy, but also in terms of locating and grounding it in the overall development strategy of the country. Nutrition has to be tackled independently along with other development issues". The survey reports of National Sample Survey Organization (NASSO) and the National Nutrition Monitoring Bureau (NNMB) have found that 34 per cent of the households have a household per caput/month expenditure below Rs. 60/- and 60-70 per cent of the households have an average per caput food expenditure /mensem of Rs. 73 to 80. This means that the earnings of the households (34%) are considerably less than the average expenditure on food.

Health Policies and Five Year Plans

Provision of health care for women was recognized as early as in the First Five Year Plan itself. The Bhore Committee (1946) and National Planning Committee (1948) both accorded high priority to maternal and child health. As a result, maternal and child health centres (MCH) and family planning clinics were opened during the First Five Year Plan, Sub centres were established and staffed by Auxilliary Nurse Midwives (ANMs). Primary Health Centres (PHCs) were set up at the Block

level. During the first two plans, the strategy included:

i) Expansion of physical infrastructure for health,

ii) Initiating the family planning programme,

iiI) Control of communicable diseases,

iv) Establishing facilities for training, especially female health personnel.

Limiting of family size and proper spacing of births were emphasized from the First Plan itself. During the Second Plan, MCH services became an integral part of overall health services in rural areas. It was also decided to employ and train female health personnel, resulting in greater number of nurses, ANMs, and Lady Health Visitors. Training of female health personnel, measures to control family size and efforts to expand basic health care facilities continued even during the Third and Fourth Plan periods.

The Third Plan emphasized the improvement of services at PHC level, at district and subdivisional hospitals. Financial allocations for family planning activities were also increased. Though initially, these services were provided primarily through specialized family planning clinics, the need to integrate them with general health services was soon realized. During the Fourth Plan period, MCH services were integrated with family planning.

The main objective of the Fifth Plan was to 'provide basic public health care facilities, integrated with family planning and nutrition for vulnerable groups – children and expectant and nursing mothers.' Several schemes were started during this period to cater to the health of the mothers. During this time, a scheme was launched to train traditional birth attendants (TBAs), so as to have one TBA per 1090 population. The Integrated Child Development Services Scheme (ICDS) introduced in 1975, although primarily for children, provides health, nutrition and family planning services to expectant and nursing mothers.

During the Sixth Five Year Plan, the National Health Policy was formulated and accepted for implementation. The Policy set well defined goals for women's health, reduction in maternal mortality, increased coverage of expectant mothers with antenatal care and control of communicable diseases among others.

The Seventh Five Year Plan (1985-92) stated that primary health care would be the main sphere of action, and care of pregnant and nursing mothers and children would be a priority. The seventh plan focussed on issues like:

- Increased investment in FPP programme,
- Child survival was emphasised in MCH,
- Poor performance of GOBI-FFF (selective primary health care) admitted,
- Raising health consciousness through education and communication proposed,
- Besides vertical programme of malaria, filaria, leprosy, blindness control, non communicable diseases programme was also introduced.

The Eighth Five Year Plan (1992-1997) too came out with various strategies like basic minimum facilities to all, health for all, strategy to health for under privileged, strategy to consolidate and not expand PHC, strengthening education, equipment, drugs; privatization of medical care; opening up of public sector in health to private enterprises, etc. The plan also emphasized on health policy focussing on promotion of contraception, sterilization, safe motherhood and child survival.

The Ninth Plan (1997-2002) addressed inter-regional disparities; targeted underprivileged; placed participatory process at the centre of social planning; focussed on improved quality of life and employment; emphasized food security and basic minimum services, filled gaps in infrastructure and manpower to increase the efficacy of system.

Maternal Health Programmes

Maternal health care has been a part of the family welfare program since its inception. Interventions were identified and vertical schemes, namely national nutritional anaemia control programme, TT immunization of pregnant mother (part of immunization programme) and Dais training program were introduced over the years. During the Eight Plan, maternal health programmes were integrated with other programmes and became part of the programme. Since the health of the mother affects that of her child, health services for the two are provided together. Maternal and child health services (MCH) are a part of total health care and are provided to the community through the existing health infrastructure in rural and urban areas.

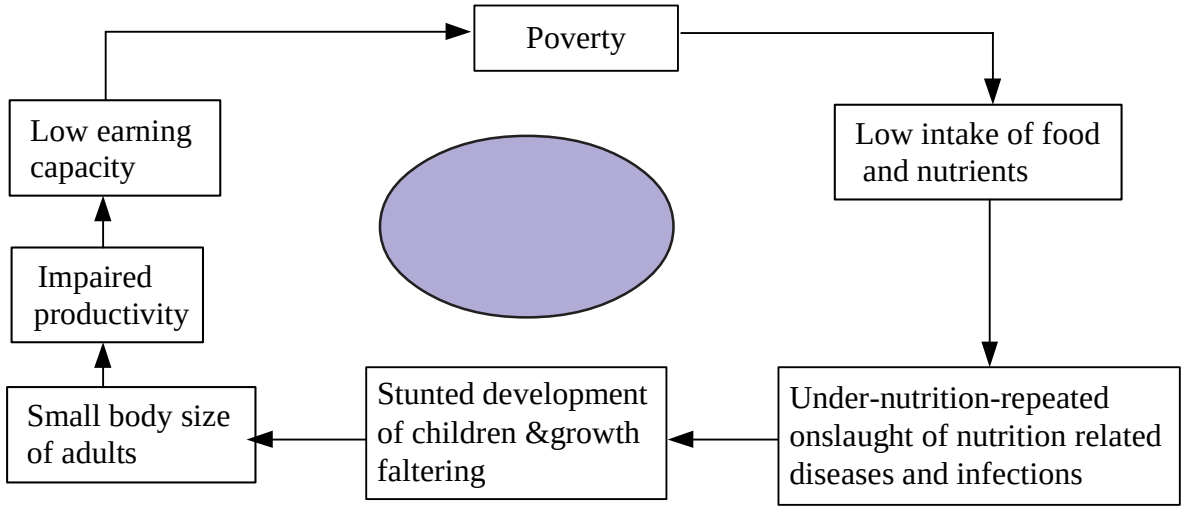
Among the services being offered is the prophylaxis scheme against nutritional anaemia to mothers and children. Under this scheme, expectant and nursing mothers and children in the age group of 1-5 years are given a daily dose of iron and folic acid for a period of 100 days. The programme is implemented through the Primary Health Centres and subcentres. The percentage achievement of the annual target during 1989-90 was 20.4 in case of mothers. Goitre is caused by insufficient iodine in the dietary intake. If the pregnant mother suffers from iodine deficiency, brain development of foetus is likely to be affected, which leads to a condition called 'cretinism' in the child. A cretin suffers from mental retardation, stunted growth, speech and hearing defects and neuromuscular disorders. To combat this, iodized salt is made available in endemic regions under the Iodine Prophylaxis Programme. The Universal Immunisation Programme is a part of the package of services. It is specially aimed at children in a bid to bring down infant and child mortality. Under this programme, expectant women are administered two doses of tetanus toxoid.

The other major programme geared towards maternal and child health is the ICDS, which provides for health and nutrition education. An increase in the health and nutrition knowledge of women prevents malnutrition, enhances child survival rate and influences the health of the mother as well. Under the ICDS programme, health and nutrition education is imparted to expectant and nursing mothers and women in the age group of 15-44 years. The messages are related to infant feeding practices, immunization, utilisation of health services, family welfare and environmental sanitation. This information is imparted to them by ICDS functionaries, Medical Officers and ANMs.

Government of India launched the Expanded Programme of Immunization (EPI) in 1978. The objectives of the programme were to provide vaccination to all eligible children and pregnant women, and to achieve self-sufficiency in the production of vaccines required for this programme. The programme is aimed at covering infants with three doses of DPT and Polio, and one dose of BCG and Measles vaccine before the age of one year. Pregnant women are given two doses of TT to prevent neonatal tetanus in children. Up to 1988, 86.3 per cent of the target group of expectant mothers had been covered by EPI (Source: Annual Report 1988-89, Ministry of Health and Family Welfare, GOI, p. 206).

One study (Jesudason and Chatterjee, 1979) found that few people were aware of the services available at PHCs. Those, who had some awareness of governmental

health services, thought of the PHC as a place for sterilization or complicated deliveries. It also found that few women had the time, ability or money to travel to a PHC or hospital several miles away. Those who did spend a long time waiting to see the doctor also complained of medicines being in short supply.



The Vicious Cycle of Poverty

Policies and Programmes for Enhancement of Women's Health Status

The Government of India proclaimed the national health policy in 1983 following the recommendations made by the Indian Council of Medical Research (ICMR) and Indian Council of Social Science Research (ICSSR) joint committee on health report 1981 (Alternative strategies health for all) the Alma Ata Charter of WHO on primary health care (1978) influenced the recommendations in this report. The national health policy however, did not give separate identity to health issues related to women and formulate strategies and approaches to address them. The reference to women's health became an incidental issue.

The population policy with the initiation of the Family Planning Programme (FPP) from 1952 focussed on fertility control of women. The consequences of this were:

- Entire responsibility of contraception fell on women with consequential side effects on their health.
- The role of men in family planning was overlooked.
- Other health needs of women were ignored.

The report of the committee on the status of women in India 1974 – 'Towards Equality' focussed among other things, on the declining sex ratio in India and attracted international attention. The education policy (1986) attempts to look at the specific needs of girls and women. 'Shram Shakti' – the report of the national commission on self-employed women and women in the informal sector (1988) recognised the occupational health hazards of women.

The national perspective plan for **Women** (1989) emphasized on a holistic approach to women's development. This recognised the need for action in diverse fields for improving the social and economic status of women. The national nutrition policy (1993) expresses concern for the nutritional status of women.

The India country report 1995 for the United Nation's Fourth World Conference on women at Beijing identified critical areas of immediate attention. The government

of India committed to formulate a national policy on women at the Fourth World Conference. A women empowerment policy was made in the year 2001. The policy made a specific mention of reviewing all national policies and incorporating specific gender concerns in them. It also suggests inclusion of gender concerns as a mandatory provison in new sectoral policies that are yet to be formulated/finalised.

Most of the sectoral development policies have not been specifically gender sensitive. The industrial policy, the forest policy, the national water policy, credit policies issued from time to time, drug policy, etc. do not address gender issues. Other sectoral policies in the area of education, welfare, labour, rural development and economic development have influenced women's lives and their health.

The three main departments relating to women's health are Department of Women and Child Development under the Ministry of Human Resource Development, Department of Health and Department of Family Welfare under the Ministry of Health and Family Welfare. A comprehensive approach to women's health has been elusive owing to inadequate coordination between the three departments, as also with other sectors relating to women's lives. It is, therefore, urgent to recognize women's health as an important component of the national health policy, apart from formulating a comprehensive policy for women's health. The national policy for empowerment of women advocates recognition of women's health needs as a priority of the health policy.

Check Your Progress II

Note : a) Use the space given below for your answers.

b) Compare your answers with the text.

1) What are the services provided for women under the following schemes?

i) Prophylaxis against nutritional anaemia

ii) Universal Immunization Program

iii) ICDS

iv) Policies focussed in the Eight and Ninth Plan.

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2) Write a para each on:

- The National Health Policy
- National Nutrition Policy
- Women Empowerment Policy 2001.

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3.6 LET US SUM UP

The situation regarding women's health and nutrition may be summarized as:

i) Disparities in health care services in different areas and different socio-economic groups.

ii) Socio-cultural attitudes and practices, which discriminate against females, thereby affecting their health and nutritional status.

iii) Low levels of health and nutrition due to repeated pregnancies and maternal morbidity.

iv) Inadequate resources including health care facilities, especially antenatal care, thus affecting maternal and child health.

v) Illiteracy and a general lack of awareness regarding health and nutrition.

Health and malnutrition of women is a serious problem as it interferes with the development of human resources. There are several indicators of the low levels of health and nutrition among women. Some of these are anaemia, low weight and height, proportion of LBW babies and maternal mortality. You have seen that while the female child is biologically superior, several factors act against this 'capacity' and contribute to her ill health and malnutrition. Prominent among them are illiteracy, early marriage, repeated and closely spaced pregnancies and socio-cultural factors. Currently, it is the MCH programme, which provides health care facilities to expectant mothers. You have also read that the National Health Policy emphasizes the need for providing better health care to women. The Prophylaxis scheme against nutritional anaemia, the Universal Immunization Programme and the ICDS are major schemes, which cater *to* the health and nutrition status of the mother and, subsequently, enhance her quality of life.

3.7 SUGGESTED READINGS

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