

# **The Role of Women in a New Health Order /by C. Gopalan.- New Delhi: The Centre for Women's Development Studies. 1990. 53p. (7<sup>th</sup> J.P. Naik Lecture)**

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## Preface

The Committee on the Status of Women in India was seeking assistance of experts from various fields to gather needed data for its investigation, it received varying responses. One of the most generous and supportive was from Dr. C. Gopalan, the then Director of the National Institute of Nutrition (NIN) at Hyderabad. I remember my first meeting with him in the NIN when he talked for more than two hours to Dr. Phulrenu Guha and myself on the nutritional and health status of the "invisible majority" of women in our country, for whom the Constitution had guaranteed equality of rights, opportunities and status. Through this two hours lecture, he kept throwing at me in valuable material in the way of studies, papers and statistics, which ultimately provided to ignorant persons like myself the base line understanding of major issues, of Indian women's health. In a talk which I broadcast from the All India Radio on the Committee's findings in early 1975, I referred to a few "angry men" that we had met during the course of our investigation and who had helped us to arrive at some of our most significant conclusions. Dr. Gopalan was one of the angry men. Fifteen years later, when I requested him to deliver the Seventh J.P. Naik Memorial Lecture, his response was characteristic. "Now can I say no to you, particularly when it is to commemorate J. P. Naik?". During the interval of fifteen years, there has been no substantial change in the issues of women's health that had caused his anger at a society and a government that could remain so indifferent. But there is a change in the key actors, in the drama. A new entrant on the stage has tempered Dr. Gopalan's anger with a tinge of hope. The revitalised women's movement may provide the force for change,

hence the title of the lecture, and its note of appeal to the movement, not to become "a limited crusade for the promotion of narrow sectarian interests", but to be broad-based in its concerns, and thus a force for national development. Like Naikshahib, to whom he pays rich tribute, Dr. Gopalan has the faith that once they are released from their present shackles of illiteracy, ill health, under-nutrition, poverty and overwork, millions of Indian women, who today constitute the most deprived section of the population, can become a force for healthy nutritional development. Their war against poverty, ill - health, illiteracy and injustice, in his view, can be far more effective than current efforts by the establishment to scratch these problems at the surface.

"Our women do not stand in need for doles, charity and concessions. Their disabilities spring not from inherent deficiencies but from constraints imposed on them by an unjust society".

The new health order that he dreams of is very different from what we have today, a top-down structure, in which the 'Centre' is represented by the Central Health Secretariat and the 'periphery' by the millions of people. He would like to see a health order that builds on active community participation through institutional network of village level women's organizations, a continuous generation of cadres of educated and trained young women as 'development brigades', involvement of the rural school system in the programmes for health, education and development of a modern information system to provide back-up support, signal distress in emergencies, and maintain two way communication between the community and the professionals. Above all, he wants re-orientation and better direction of the ICDS anganwadis. There are many other detailed suggestions that he makes in pleading for the new approach to a health order, which he has been making on several occasions in the past, to various sections of the community and the establishment. But this time his appeal is to the women's movement, because he believes that women are better equipped "to play a key role in spearheading and sustaining movements for upliftment of health, well being and socio-economic status of families and communities".

I hope Dr. Gopalan's appeal will be taken seriously at this juncture when the women's movement is taking stock to develop, its strategies for the future.

Centre for Women's Development Studies  
New Delhi, 7 February 1990.

Vina Mazumdar

## I

### Introduction

I deem it a privilege to have this opportunity to pay my tribute to Shri J. P. Naik. I had known J. P. rather intimately during the years when I headed the Indian Council of Medical Research. I drew rather heavily on his support and wisdom in those years. Through our joint efforts, we instituted, for the first time, the joint ICMR-ICSSR panel, where he helped me to initiate steps for drawing up a Code of Ethics for medical research involving human subjects and communities. He was an active member of the National Drug Abuses Committee of which I was Chairman, and we were both members of the Srivastava Committee on Health. J. P. was always the 'live-wire' in any committee he sat on; he dominated the proceedings not because of any official 'clout' but because he was a rich store-house of constructive innovative ideas which he espoused with vehemence, but no rancour. He combined dynamism, integrity and idealism with homespun simplicity. He was a constructive and creative 'activist'-not a cantankerous one. In his rather premature death, education, health and women's movements in the country had lost an ardent champion. I thought it would be appropriate for me on this occasion, to speak on 'The Role of Women in a New Health Order', because this seemed a subject which, in a sense, encompassed the three major concerns of J. P. in his long crusade-namely Health, Education and Women's status.

In recent years, thanks to the efforts of several voluntary agencies, there has been a growing national awareness of the deficiencies in our health and education systems, as also of the enormity of the deprivation discrimination to which our women are subjected to. If this awareness is channelized in constructive directions that could promote reappraisal of our present strategies and a reordering of the existing systems, the country will stand greatly benefited. The time has come for an honest, in-depth examination of the factors that underlie (1) the Poor out-reach of basic primary health-care to our rural masses despite impressive investments in our Public Health System; (2) the persistent high rates of female illiteracy in most parts of the country despite a vast programme of Primary Education, and (3) the shockingly poor status of large sections of Women of our society, both within the family and in the community at large. Fortunately, we already have some indication that the need for such reappraisal is now being widely recognised. The National Perspective Plan for Women Report is welcome indication that, at the highest levels of our Government, it is now being openly recognised (and publicly owned) that our efforts a upliftment of the status of women during the last forty years after independence, have been inadequate and that new initiatives are now needed-this, despite the fact that we may not agree with all the 'solutions' suggested in that report.

The recently announced New Education Policy which aims to promote universalisation of elementary education, reduction of drop-outs at the primary level, education of girls and vocational education at secondary stage to prepare students for self-employment, is another welcome recognition of our shortcomings on that education front. What we now also need is a clear enunciation of a New Health Order which takes due note of the errors and deficiencies of the present Health System.

However, it is not through populist patchwork that we can reverse the current erosion of, not just the status of women in our society, but of the quality of human resources in general. The root causes of this erosion, which are related to Current Value systems and prevailing 'socio-economic culture', must be addressed, and these will not be addressed by 'gestures' and 'concessions'. We need to address the basic malady-not just the outward symptom.

Before we go on to a consideration of the possible role of women in a New Health Order, some comments on current strategies for upliftment of women's status and on the limitations of our present education and health systems, may be in order.

## II

### Status of Women

It is gratifying that movements for upliftment of the status of women have gained considerable momentum in recent years. These movements concern not just women but the country as a whole.

While there are undoubtedly specific issues affecting women that require special attention, it will be unfortunate if we let efforts related to the cause of women get reduced to the level of the numerous movements by narrow 'special interests groups' in the country. The cause of women is important and vital-not just for women but for children, men and the country as a whole, and cannot be relegated to a *cul de sac* and treated as yet another 'special interests' issue.

While, as I have said earlier, there are specific issues related to women that should claim special attention, the problems that beset women of our poor communities by and large, must be viewed in the larger total context of pervasive poverty, ill-health and under-nutrition (affecting not just women but men and children as well, in several millions of poor households in the country), of the exploitation of the weak by the strong, and of the 'have-nots' by the 'haves'.

The great bulk of women's issues among poor segments of our population stem from the deepening socioeconomic inequities which currently disfigure our national scene. While the brunt of these inequities undoubtedly is borne by poor women, poor men are not much better off. Under the circumstances, it is bad strategy to project current disabilities of poor women as mostly arising from 'sex-discrimination'. While sex-discrimination is undeniable, a dispassionate analysis will show that the 'discrimination' against the poor by the rich, which is inevitable and inherent in the current socio-economic order, contributes far more heavily to prevailing disabilities of women. Indeed it may be argued, with some justification that, at least among the poor, 'sex discrimination' to some extent springs from the imperatives imposed by poverty and is therefore its by-product. By directing women's movements in a manner which pits one half of the poor (the men) against the other half (the women), we may be helping the 'real culprit' to get off the hook-and this will suit vested interests. The vast bulk of problems of ill-health and under nutrition the afflict women in the country arise from poverty, illiteracy, poor health care and insanitation, and men and children of the poor are by no means exempted.

Let me illustrate this with some data. In Graph 1, body weights of men and women belonging to the poor and high income groups in the country have been indicated. While it is naturally to be expected that men will have higher body weights than women, it will be noted that the differences between body weights of women and men in the poor groups in India are actually less than the differences between body weights of well-to-do American men and women. The differences between the body weights of rich and poor Indian *women* actually exceed the weight differences between poor Indian men and women. Body weights of adult men in poor households in India are, actually lower than those of well-to-do adult Indian women! It is the poor-both men and women-who are usually engaged in unskilled manual labour, where productivity and wages are related to physical stamina and it is they that need a sturdy body build, not the sedentary rich - men or women! Let us not forget that at least 50%, if not more of our population falls in the 'poor' category. What this situation demands is not just a campaign against 'sex discrimination', but a campaign against poverty and socio-economic exploitation.

Graph 2 sets out the comparative position with regard to growth and development of children and adolescents-poor and rich. The message that emerges is the same-that the most outstanding determinant of the present poor nutritional status of women in the country is poverty, which afflicts vast segments of the population and that the situation calls for a *war against poverty* and not a war between sexes (at least among the poor).

All this is not to deny that girls and women suffer greater disabilities and worse deprivation than boys and men even in poor households. The data in Table I indicate that the relative risk of mortality of females up to the 30th year of age exceeds that of males not only in the most populous States of the Hindi belt in the country (Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan) but in prosperous Punjab and Haryana as well. The striking and refreshing contrast is provided by Kerala. However, close scrutiny of data in Table 2 will show us, that given nearly, the same order of difference in *relative* risk in mortality between female and male children, overall mortality in female children is far less in Punjab and Haryana than in the Hindi

States. This would indicate that while we must fight discrimination against girls, our major concern at the present stage, as far as health is concerned, must be to improve the outreach of health care and to reduce overall infant and child mortality from the present totally unacceptable figures prevailing in the Hindi States, to levels prevailing at least in Punjab, if not to those of Kerala, within the next ten years. Our concern is certainly not to ensure that boys and girls suffer *equal* risk of mortality rate, which will benefit both boys and girls. It will do the girl-children of Uttar Pradesh not much good if all that we seek to achieve for them is *equality* with boys at prevailing levels of mortality in Uttar Pradesh.

In short, I am pleading for a broadening of the concerns of women's movements in general and for their direction and projection as an endeavour for overall national development rather than as a limited crusade for the promotion of narrow sectarian interests. Improvement of the status of women has to be perceived and promoted not as an end in itself but as the important means of achieving prosperity, health, harmony and happiness for the entire family and indeed for the community as a whole. There is much complementarity and certainly no inherent conflict, as between the roles, needs, and interests of women, children and men. Women are naturally endowed to play a key role in spear - heading and sustaining movements for upliftment of health, well - being and socioeconomic status of families and communities. In particular, women can play a major role in the promotion of health, nutrition and welfare programmes in the countryside; but this they can do only when they are freed of current shackles. Where women are denied opportunities for education and acquisition of skills, it is not just 'women's status' that suffers but the nation is denied the rich contributions that women (freed of shackles, illiteracy, ill-health and under nutrition) can make towards its over all development.

### III

#### Education for Women

From all available data, the single factor, which emerges as the most important requisite for 'development', of not just women but of a nation or country, is the level of female literacy and education. It is the present striking deficiency in this basic requisite that lies at the heart of India's problem-of not just poor status of women, but of its overall underdevelopment, of poor implementation of health, welfare and rural development programmes. Rural female literacy rate in the country as per the official figures for 1981 stand at the shockingly low figures of less than 18%. According to the National Perspective Plan for Women Report, <sup>1</sup> "the gap between male and female education is wider now than it was in the former half of this century"! School enrolment of girls in the decade 1971-81 has shown only a marginal rise; but as against this, nearly two-thirds of all girls enrolled continue to drop out at the primary level and more than three-fourths (77%) at the elementary stage. The National Perspective Plan for Women Report also provides the depressing estimate that by 2000 A.D., India will account for nearly 55% of the world's -illiterate population in the age group 15-19.... this mass of illiterates refers overwhelmingly to women. It must by now be clear that this staggering trend is not going to be reversed by the opening of more schools. By all means let us strive to promote school enrolments and discourage drop-outs by ensuring locations of schools closer to homes, recruitments of more women teachers for rural schools and possibly other incentives such as provision of hostel accommodation for girls etc. But clearly, these measures will prove inadequate in the face of present social imperatives, which pose formidable hurdles to female education. Till such time as we are able to overcome these hurdles, we must resort to innovative strategies which will at least serve to impart basic education and vocational skills to the ever-increasing numbers of adolescent girls and young women who will shortly usher in the generation of the 21st century.

High levels of female literacy have contributed significantly to the great Asian success stories, not only in the field of economic development but in the areas of health, nutrition and family planning. Behind the dazzling success of Japan and South Korea lies the fact, that an overwhelming majority of women in those countries are educated. Thailand and Indonesia which are now clearly forging ahead of India in the field of Health, Nutrition and Family Planning also owe their success to their high rates of female literacy. The literacy rate in Korea is over 95% and in Thailand, nearly 85%. Within India itself we have convincing

evidence of the overwhelming importance of female literacy as a major determinant of the efficiency of implementation of Health and Welfare programmes (Table 3 and Table 4).

For some years now, I have been pleading (in vain) for a comprehensive and concerted programme of education and vocational training for adolescent girls and young women in rural areas.<sup>2</sup> The National Perspective Plan for Women Report makes a rather feeble and vague reference to "integrated learning programmes which will not only lay emphasis on literacy but on empowering women through awareness building on social issues, promoting skill-training for employment, providing information on health care, nutrition and hygiene as well as on legal rights". The report, however, does not reflect much enthusiasm for strategy and in fact dismisses it with the pious statement "such programmes are beginning and must continue to be designed and structured so as to be relevant for the vast majority of rural women". Operative recommendations for implementation of such a programme do not figure under either general or specific recommendations in the report.

I must confess to the feeling that the National Perspective Plan for Women Report, while being strong in its preamble, is rather weak in its operative part. If the present draft in the field of female education with all its baneful repercussion is to be arrested, we certainly need more vigorous and purposeful action.

Our Women do not stand in need of doles, charity and concessions. Their disabilities spring not from inherent deficiencies but from constraints imposed on them by an unjust society. If we Pursue a populist approach in combating this problem. We will end up in perpetuating not only female illiteracy but also national under-development. Of all the bonds, which fetter women today, the most incapacitating one is that caused by illiteracy. When women are liberated from this fetter, we will be releasing a mighty force which will transform our countryside. A substantial slice of our Plan investment must go towards the setting up of innovative rural programmes-in and outside schools-which will address the problems of illiteracy and ignorance in our adolescent girls and young women-the mothers-to-be. The returns from such investment in the form of better implementation and utilisation of Health, Nutrition, Family Planning and Welfare Programmes will be truly substantial.

Knowledge is power; and where knowledge is combined with vocational skills, the genetic potential will find full expression. Today the country is being denied the benefits of the enormous potential energy which lies locked, imprisoned and untapped in millions of women in our countryside. I still plead for the immediate large-scale implementation of the Plan of Education for better living and vocational training for rural adolescent girls which I had advocated some years ago. This plan aims at instituting a continuing programme of broad-based education of rural adolescent girls and young women, based on audio-visual aids and cassettes which will run side by side with a programme of vocational training; such a programme will provide an immediate answer to the vexing problem of poor school enrolment of girls and the persistent high drop-out rates. It will also help to generate in each village within the next few years, a cadre of trained, educated, young women volunteers who could act as resource persons and animators for the village women's associations and who could serve as the link between the village community Organisation and the government services. From this cadre, suitable candidates could be chosen for appointments at various levels of the paramedical force, as rural school teachers, and in various rural development programmes, after such further training as may be necessary. With this, health, nutrition, welfare and rural development programmes will become people's programmes based on self-sustaining efforts involving women and not remain mere bureaucratic operations as at present. Since I have discussed this Plan repeatedly at other forums, it may not be necessary to dilate on it further here.

#### IV

### **The Health Scene-Why a "New Health Order"**

Now I turn to a quick review of the National Health Scene and argue the case for which I call a "New Health order". On the basis of every health parameter including the much publicised 'reduction' in Infant Mortality Rate and increase in life-expectancy, our performance on the health front (taking the country as a

whole) has been well below our needs and expectations-indeed well below what we could have achieved even with the resources and inputs that have gone into our health sector in the Centre and the States. The only tangible 'advance' has been with respect to the number of medical colleges and the growth of specialities and super-specialities in medicine and surgery-and I most certainly do not deride or deprecate this real achievement. I am convinced that our failure to achieve effective outreach of basic health care to our rural masses is not attributable to diversion of resources for the growth of medical colleges and specialities as is often stated. Even if we had totally stopped the growth of our medical colleges, the state of rural health care in the country would not have been very different-only, we would have ended up with being also more backward than other countries even with respect to medical teaching and modern medical treatment. Our failure must be traced to some other, more basic causes.

It is not necessary for our purpose here to list a long catalogue of our deficiencies in the public-health picture; but we may provide some data which will indicate the enormity of the unfinished tasks that lie ahead-tasks that can only be accomplished by new strategies. Our overall Infant Mortality Rate has been declining at such a painfully slow rate that within the last two decades, we have been overtaken by practically all other Asian countries except Bangladesh and Nepal. Infant Mortality Rate in our most populous state of Uttar Pradesh, according to the latest reports, actually exceeds 140 per thousand live births. Nearly two-thirds, of all infant deaths in the country take place within the first month after delivery-an indication of poor antenatal and obstetric care. In fact, 75-85% of deliveries in the four states of the Hindi belt in the country are being Conducted in unhygienic rural homes by totally untrained 'birth attendants'. More than one-third (probably an underestimate) of infants born are of low birth weight possibly because of maternal undernutrition, and because of such poor start continue to grow in a substandard growth trajectory to end up as stunted adults with poor physical stamina and mental abilities.

The health hazards to which women, who seek to eke out their living by working outside their homes, are being exposed have been highlighted in the useful report on "Occupational Health issues of women in the Unorganised Sector" prepared by the Health Task Force of the National Commission on Self-employed Women.<sup>3</sup> If the National Health Scene in the twenty-first century is going to be any different, we must reorder our Health System in the light of past experience.

**Development** is likely to generate problems other than those related to occupational health as well. With increasing life-expectancy, urban migration of men and break-up of joint families, geriatric health problems of destitute women in rural areas are likely to worsen. Our concern with respect to women's health must, therefore, extend beyond childhood, adolescence and the reproductive period to older women as well in the years to come.

There are three major factors that could possibly account for the weaknesses in our present Health System.

**1. The 'Centre' and the 'Periphery'-The Invested Image:** At the very first session of the meetings of the Srivastava Committed on Health, a senior official of the Health Ministry referred to the 'Centre' (by which, of course, he meant Nirman Bhavan, the Central Health Secretariat) having 'made provisions' which were not being implemented at the 'periphery' (by which he meant the village). In a characteristic intervention, J.P. Naik stopped him in his tracks and asked him which was the 'Centre' and which the 'periphery', and followed up his question with the admonition that the major part of the ills that beset the health system was traceable to this inverted perception of the health administrator; the village, the front-line where the action live and where the battle against ill-health has to be joined, was now out of focus as the 'periphery' while the Secretariat looms large as the 'centre'. This classical intervention which encapsulated much of what followed, set the tone for the subsequent deliberations of the Srivastava Committee. The ICMR-ICSSR Health For All by 2000 A.D. which followed years later has more or less endorsed and elaborated this theme. The message is that there is need for a change in attitude and perception on the part of our health administration, in order to ensure that the main focus in health operations shifts to the village. This implies not only effective decentrisation of Planning and Policy formulation but also a mechanism built into the system which will help the administration to know what is really happening in the field and what the people-the 'beneficiaries' or 'recipients of Health Care' have to say. The yawning gap between promise and performance, between 'claims' and real achievement, can only be bridged when we covers the current information gap between the two ends of the health administration spectrum. With the village where the action really lies, now out of focus, our health administrators are much like generals trying to direct a war

with no feed-back from the battle field. Our health, family planning, welfare and rural development programmes today are, for this reason, largely 'blind operations'. It is not surprising, under the circumstances, that no less a person than the Prime Minister himself made the astonishing confession that out of every six rupees being currently spent on rural welfare development operations in the country, only one rupee really reached the people.

- 3. Lack of Community Involvement:** This brings us immediately to the vexed question of 'community involvement'-about which a great deal has been (and is being) said but not much has been done, Health, family planning and nutrition programmes, unlike turn-key industrial production operations, involve efforts aimed at bringing about changes in intimate living habits and social customs of people steeped in long years of tradition. These programmes can only succeed when it is recognised that the 'recipient' or beneficiary is at least as important as the 'provider'. This implies the imperative need for the formation of a net-work of viable effective community organisations at the village level which could act at the basic institutional infrastructure-the nodal points through which all health, nutrition, welfare and development programmes will be implemented. In such Community organisation<sup>8</sup> it is the women of the village that should be mainly involved. Indeed, in some villages, women's clubs (Mahila Mandals) could be the nodal community Organisation through which health and welfare programmes could be implemented. Currently, in the absence of such community institutions, meaningful and effective interaction between the provider and recipient is difficult, there is no mechanism for feed-back, no accountability and no facility for a genuine achievement audit. This must be considered as a major deficiency in the present health order. I have dealt with this question at some length in an earlier publication.<sup>4</sup>

There are undoubtedly formidable problems involved in the setting up of viable, Effective, truly representative village-level women's organisations which can be vested with power and responsibility in villages in many parts of the country. Indeed it is precisely in those parts of the country which are most under, developed and where the need for such organisations is greatest that hurdles in the way of their formation will be formidable. Unlike Thailand, Korea or Indonesia where village communities are cohesive, in India, village communities are fragmented into castes and sub-castes, and in any village Organisation that has prospects of receiving official recognition and support, it is quite likely that women and the most deprived and needy segments (Harijans in Bihar for example) that will be marginalised, -Specific guidelines which should govern the compositions of officially recognised and empowered village-level Organisation must be laid down to prevent this, indeed it could be stipulated that, where there are composite (of both sexes) community Organisation& and not women's associations that are identified as nodal institutions, at least half of the members of such a (composite) community Organisation must be women; and that either the Chairman of the Committee or its Secretary should belong to the Scheduled Caste and that one of these office-bearers must be a woman. This may seem a tall order, but there is political will and the Government is determined to have community organisations for which they will provide financial and technical support, the hurdles will be overcome. In any case, there are not short-cuts.

The other real danger is that village level women's organizations will be sought to be politicized. Many of our village Panchayats are already being politicized. Political parties must summon wisdom and statmanship to arrive at consensus that elections and nominations to village level committee connected with health and social welfare programmes will not be fought on party lines.

Village-level committees will need at least minimal financial support. Among the factors that have apparently inhibited effort at formation of village committees and their functioning, is the fear that the funds granted may be misused. We need to assume that the changes of corruption in village-level organizations will necessarily be greater than in the current purely bureaucratic operations; in any case, where grants are disbursed, an efficient (result-oriented and not-rule oriented) adult system must be built in order to ensure management of funds.

Village-level women's organizations can function with reasonable efficiency only when they are supported by cadres of trained women volunteers in each village. Otherwise they will mere appendages, totally at the mercy of the 'providers'. The building-up of critical mass of trained women volunteers for each village who will act as 'resource persons' for the women's organization and as links between the village-women's



organization and the Government Services (the 'providers') is an important requisite for meaningful community involvement, indeed it is the crux. I had already referred to this earlier in this paper.

**3. Poor Management of Available Manpower and Suboptimal Utilization of Existing Resources:** The complaint is often being made that doctors are reluctant to move to the villages but what is forgotten is that there is a very impressive array of paramedical personnel now available (at least on paper) within the jurisdiction of each Community Health Centre (serving a population of about 10,000).

The total number of trained women engaged as paramedical personnel in Community Health Centre areas serving a population of about 100,000 (block level) could currently exceed 250. It is possible that in many blocks not all posts are filled and not all functionaries are adequately trained. Even so, it cannot be denied that if the existing staff are optimally employed, supported and encouraged and if they are backed up by an efficient information system and provided adequate facilities for transport, communication and referral, the picture with respect to rural health care in the country will be vastly different from what it is today. There can be no doubt that the impressive available infrastructure is being most inefficiently managed. This is because the system does not demand accountability and provides no mechanism for achievement audit.

The vast ready-made infrastructure of rural schools (one school within a radius of practically every village in the country) is now hardly being used effectively for the Organisation of school health and community health programmes. I had pointed out in an earlier publication that the rural-school infrastructure could be imaginatively used for opening a 'second front' in our battle against ill-health and undernutrition.<sup>5</sup> A report of the Nutrition Foundation of India had dealt in some detail with this question and had indicated the enormous untapped potentialities of the rural school system.<sup>6</sup>

I am of the view that the rural health system in the country as well as the rural school system should be predominantly serviced by women. The overwhelming majority of paramedical personnel right from the district level through the Primary Health Centre - subcentre levels to the village level, constituting what may be called 'Rural Health Services', must be women. More and more women should be inducted as teachers in charge of rural schools both at the Primary and the Middle levels. I sincerely believe that women will make far better paramedical personnel at all levels than men and possibly better teachers as well. This will not only open up employment opportunities for women but will also improve their social and economic status. The National Perspective Plan for Women Report makes a reference to job reservations for

Women. I suggest that jobs in the rural health and rural School systems as well as in rural agro-based industries and rural development programmes may be predominantly reserved for Women; the reservation should apply not just to jobs in the lower rungs of the hierarchy (this could lead to exploitation) but to the higher echelons as well.

While I Certainly would welcome more Women doctors, I think women's participation in paramedical services and in rural health and rural education operations is far More important and is likely to make a far greater impact on the national health and education services. Even in a highly developed country like Japan, only 10% of all doctors are women but the paramedical force is almost entirely serviced by women; the position in South Korea also appears to be the same.

A New Health Order must take note of deficiencies in the Health System discussed above.

**V**

## **A New Health Order**

It will be presumptuous of me to claim that I can spell out a New Health Order in all detail. I will only indicate here a brief outline of some major recommendations for your consideration. Some details regarding each recommendation here have already been provided in earlier publications which have been referred to, and for this reason they are not being elaborated.

The essence of the New Health Order could consist of a deliberate shift of focus of health operations to the village. The New Health Order should envisage the forging of a meaningful partnership between 'providers' of health care and the 'recipients'- the community; the strengthening and streamlining of the paramedical force, and most importantly, the involvement of women both as providers and as active community leaders. Some concrete steps that would be necessary for this purpose are indicated below.

### **I. Arrangements at the Village Level**

1. Promotion and institutionalization of arrangements for active community participation in the implementation of health and welfare programmes through the creation of officially recognised (and technically and financially supported) net-work of village level women's organizations extending from the village to the district. These village-level community organisations should act as the nodal points for interactions between the official (government) services and the community. All official functionaries at the village, even if they are salaried government servants, must be considered as employees of the community Organisation and answerable to it.

2. The continuous generation of cadres of educated and trained girls and young women (through a continuing programme of audio- visual education) who will form 'village health/development brigades' acting as the link between the community and the 'providers' of health care. These cadres will constitute the pool from which specially motivated candidates can be chosen for further training for employment at higher levels of the paramedical hierarchy including ICDS, Sub-Centre, PHC and even at the district levels,

3. The active involvement of the rural school system in a programme of health education of children and the community the institution of a school health service with adequate facilities for referral: <sup>7</sup> and the induction in increasing numbers of women as teachers of rural schools.

4. Reorientation and better direction of anganwadis of the ICDS in order that existing deficiencies in that system with respect to outreach of mothers and children-under-three years are overcome; also, enforcement of better functional linkages between the workers of the health system and the anganwadi worker.<sup>8</sup> This would be facilitated by the arrangement proposed earlier by which all village level functionaries, irrespective of the government sector which employs them, will be deemed to be employees of the village-level organization.

5. The development and establishment of a modern information system both at the health centres and the anganwadis which will help the health administration to identify the 'households at risk' in each village (somewhat on the lines of what has been done by the Christian Medical College in Ludhiana): This will facilitate a purposeful programme of periodic domiciliary visits to be jointly undertaken by the health worker and the anganwadi worker.

6. An 'information system' which will help to signal distress and emergency so that timely medical help could be rendered and several lives saved. If this can be done for emergencies affecting buffaloes in Anand, there is no reason why, given the political will, this system cannot be introduced for women and children-in this electronic age.

7. The introduction of the Echo scheme <sup>9</sup> -system of two-way communication (facilitated by tape-recorders) between the 'provider' and the recipient (community); This will help to ensure feed-back, so that health programmes are no longer blind operations; mid-course corrections and achievement audit will then become possible, accountability ensured, and false claims discouraged.

8. Ensuring easy mobility of professional staff from PHCs and sub-centres to villages (bicycles and mopeds): This will overcome current reluctance of PHC and sub-centre staff to move out to villages when necessary. The present system whereby health workers are denied even bicycles till they are confirmed in their appointment which usually takes more than a year and are expected till then to trek several kilometers, breeds evasion and negligence. Where the terrain is difficult and villages are distant, a system of mobile medical services - which will consist of periodic visits of medical staff and assistants to villages, may be necessary.

9. Institution of arrangements for prompt replenishment of drugs and other expendable facilities needed by the village level health worker: Currently for months together the medical kits of anganwadi workers are empty; and drugs like vitamin A concentrate and iron tablets are not being readily made available. Infact iron tablets must be made available to rural schools as well.

10. Provision of safe-drinking water: Of all the Technology Missions, perhaps the two most important ones which directly touch the rural poor are those related to provision of safe-drinking water and promotion of functional literacy. Available evidence indicates that the 'drinking water mission' is proceeding sluggishly. Easy access to drinking water will save much time and energy for poor women to contribute to better personal hygiene. Far greater attention needs to be given to this item and to the promotion of personal hygiene if we are not to depend forever on 'oral dehydration' as the answer to the problem of diarrhoeas in children.

11. The extension and enforcement of an efficient public distribution system (PDS) to the villages: this will ensure that basic food commodities needed for adequate nutrition are available at reasonable prices to the village communities. At present PDS seems to exist only on paper in many rural areas of the country.

12. The setting up of health-and-nutrition-related village-based agro food processing (and other) industries and specific training of cadres of young women for this purpose.

13. Promoting self-reliance and self-help by encouraging those members of the village community who are better off and well – to - do to contribute their mite to the community Organisation. Health and welfare operations should not be allowed to degenerate into charity operations which breed dependence and loss of self-respect. Incentives for community contribution in the form of matching grants by the Government could be considered.

## **II. Steps to overcome current distortions in the context of Primary Health Care:**

It is not just the delivery but the content of the Primary Health Care package that has developed major deficiencies in recent years.

A New Health Order must seek to correct these distortions.

1. Restoring emphasis on antenatal care and nutritional support to mothers during pregnancy and lactation: In recent years, With the intensive drive for family planning, pregnant and nursing women have clearly become low priorities in Primary Health Care. If, this trend is not arrested soon, maternal mortality and incidence of low birth weight deliveries will increase. Programmes for distribution of iron/folate to women during pregnancy must be intensified. Wherever supplementary feeding operations are undertaken, pregnant women and nursing mothers must receive priority.

2. Ensuring integrated health care: In recent years also, isolated programmes like immunizations, growth-monitoring, and supplementary feeding have been pushed in a manner that has crowded out other components of the primary health care package-such as antenatal care, health and nutrition, education, advice on child-rearing. Such emphasis on isolated programmes has proved counter-productive. Health workers especially, need to be trained in goiter-endemic areas, in simple methods of identifying if salt available in the village has in fact been iodated (methods which can be undertaken by illiterate women) and report the induction of non-iodated salt immediately to the village-level Organisation. This will greatly facilitate the implementation of the salt iodation programme for control of goiter.

3. Better use of supplementary feeding programmes for promotion of primary health care: It is understood that, shortly, supplementary feeding programmes and mid-day meal programmes in schools will be initiated on a large scale. Even if, as is being alleged, these are populist 'pre-election' political exercises, it is important for us (interested in children's welfare and not politics) to ensure that the heavy investments on such programmes are, at least, put to wise and maximal use, to improve the outreach and quality of primary health care and to develop a comprehensive school-health service. In particular, it must be ensured:

a) that the introduction of feeding programmes does not lead to neglect of other elements of the health care package, and that health workers and teachers do not just become food distributors, the attempt must be to develop a comprehensive health service using supplementary feeding as a tool and incentive.

b) that these operations do not degenerate into charity operations generating dependence, with the responsibility of providing food supplements being passed on to foreign agencies. The community Organisation should be vested with the responsibility for overseeing the programme-both preparation of food and its distribution as a cooperative effort, using, at least partly, resources generated within the village, The rich of the village should be encouraged to contribute their mite and as an incentive could receive public social recognition.

c) that the supplements are wholesome and as far as possible fabricated in the villages themselves by the community using its own resources. In short, these programmes should become a 'people's movement' to which the government will provide partial financial, technical and logistic support. Ready-to-eat, village or, home-processed foods prepared by village cooperatives and rural cooperative bakeries may be used for institutional feeding programmes; the food may also be offered for sale for those who can afford to pay, so that the programme becomes partially self-sustaining. This approach could also help generate some employment in the village and most importantly it will promote self-respect and self-reliance among the poor. Great care must be taken to ensure that the programme does not become a means of disposing of food of poor quality.

### **III. Arrangements for augmenting back-up support to village level operations and for strengthening links in the health care chain.**

1. Strengthening referral facilities within the Health System- from the village anganwadis and from rural schools to the PHCs, Community Health Centre and District hospitals: Patients from villages referred to these higher centres, when accompanied by a member of the cadre of village-level volunteers and with an official note from the anganwadi worker or school-teacher must receive prompt attention and efficient treatment. Special counters for such referred cases could be set up at PHC and Community Health Centres. At present after trekking several kilometers and losing an entire day's wage, villagers often end up getting scant attention and poor treatment leading to poor utilisation of even existing facilities. If PHCs are overcrowded, private medical practitioners could be inducted on a part-time basis and suitably remunerated. If patients choose to consult a practitioner of indigenous system, this may be allowed and the practitioners may be appropriately remunerated.

2. Strengthening the paramedical force: This should be predominantly serviced by women. More attractive opportunities for career promotion within the system could be offered. The upgrading of the post of 'multipurpose workers' to that of Health Scientists (B.Sc. Health Science) with better salaries and introduction of training programmes for such upgradation could be considered.

3. Steps to ensure that the benefits of latest advances in medicine are made available as near the villages as possible so that rural masses may also have access to them: The continued growth and development of specialities and super-specialities and the maintenance of the highest standards of medical education must be ensured. However, in order that rural masses get the benefit of the most modern medical care, district hospitals must be equipped with the latest diagnostic and therapeutic facilities and specialists in all major disciplines must be available at the district level hospital. Specialists in major disciplines-Medicine, Surgery, Orthopaedics and Paediatrics must be available at the Community Health Centre.

4. Setting up of Advanced National Institute of Public Health: In order to generate a corps of medical specialists with better training in preventive and promotive health care, to upgrade training programmes for paramedical personnel, and to impart skills in the field of health, education, communication and information systems, Health Management, Biostatistics and Epidemiology, six Institutes of Public Health (on the lines of IIT) could be set up in six different regions of the country. This will not only promote better knowledge of preventive medicine but will ensure better Prestige for that speciality in the hierarchy of medical specialities.

I am aware that the above suggestions could evoke two divergent cynical reactions-one, that there is nothing 'new' in the so-called "New Health Order" and that all that I have said here has been said before;

and two, that the recommendations are 'utopian' and not realistic. I will not waste time defending the 'newness' of the suggestions here; I will be glad to concede that they are all 'old', provided these 'old' suggestions are implemented. As for the second criticism, I do not minimise the several practical problems involved in the implementation of some of these recommendations. Let us, however, not forget that 40 years after our Independence, we have now reached a situation in which while we may be the tenth industrial power in the world and the third with respect to scientific manpower, we are perhaps only three places from the bottom even among Asian countries with respect to our performance in the health field. The situation does call for bold innovative measures and does not brook cynicism or complacency.

## Appendix A

### **Working Group on Women's Health**

#### **National Perspective Plan for Women: Debate Report, from the Women's Movement, August '88**

#### **A Perspective**

Fundamental to any review of the health status of women in India has to be an analysis of the socioeconomic factors accounting for the pitiful condition of overall health in the country. Yet the section on health in the Draft National Perspective Plan for Women suffers from the inherent flaw of a failure to perceive this and thus we are given only a partial and fragmented view of the causes of what the Plan itself has identified as the downward health and nutrition spiral of Indian women.

India has among the lowest life expectancies in the world. 75% of all diseases in India are due to malnutrition, contaminated water and non-immunisation. Of the 23 million children born every year 2.5 million die within first two years. Of the rest one out of nine dies before the age of four and five out of ten suffer from malnutrition. As the Plan has pointed out, women from infancy to adulthood are the worst victims of this assault of malnutrition as victims of social discrimination. Yet the ground reality is that even when the food grain production in India increased from 82 million tonnes in 1961 to 124 million tonnes in 1983, the per capita intake decreased from 400 gms of cereals and 69 gms. of pulses of 392 gms and 38 gms respectively. Due to the increasing economic burden on a majority of the people-a consequence of the blatant and sharp unequal distribution of the wealth and resources of the nation- they just cannot buy the food that is theoretically available.

It is in such a situation that Indian women have to suffer the double burden of oppression. The health of the vast majority, of women already adversely affected by increasing poverty and exploitation, they yet have to face added discrimination due to the bias against them inherent in our society.

#### **Erroneous Approach**

And yet the draft Plan in its section on health starts by stating 'Any serious attempt to improve the health of women must deal first with the biased social customs and cultural traditions'. Is one of infer that the only, or even main constrains in improving the health status of women are biased social customs and cultural traditions. This is an erroneous assumptions as part from ignoring the ground reality mentioned above, it seeks to negate the impact of a grossly inadequate health care delivery system on women's health.

The draft goes on to add at another point "The enormous wastage of female life and well-being occurring at present has been demonstrated to be well within human capacity and existing resources to contain." What is fails to add is that such a possibility can be visualized only if there is a radical restructuring of priority in our socio-economic framework. Otherwise recommendations made in the draft are essentially meaningless, as our health care delivery system is not in the least geared to even take cognizance of such recommendations.

#### **Balance Sheet of Government Health Policy**

While the draft plan does point towards the need for radical restructuring of the health care delivery system in regard to women, it is completely silent about the meagre allocation of funds by the Government to Health. The following table shows the progressive reduction in budgetary allocation for health in successive Five Year Plan (not inclusive of allocation for Family Planning):

Table 1

The Result of such low priority given to health is :-

- only 20% of our people have access to modern medicine;
- 84% of health care costs are paid for privately;
- only 33% of deliveries are attended by trained people;
- maternal mortality is 400-500 per 1,00,000 live births and figures from some rural areas as high as 1000-1200. It is estimated that Indian women run a life-time risk of one in 18 of dying from pregnancy related causes. And the draft itself admits that 70% of these deaths can be prevented;
- 50% of children and 65% of women suffer from iron deficiency-anemia;
- Only 25% of children are covered by the immunisation programme. 13 million (3000 a day) children die of diseases which could have been prevented by immunization;
- 1/3 of the total population of India is exposed to Malaria, Filariasis, and Kala-azar every year;
- 550,000 people die of T.B. every year. About 900,000 people get infected by tuberculosis every year;
- About half a million people are affected with leprosy which is 1/3 of the total number of leprosy patients in the world;
- 1.5 million children die to diarrhoea every year;
- a comparison of Infant Mortality Rates (IMR i.e. number of deaths under the age of one month per thousand live births) of some countries in 1960 and 1985 shows that many countries with a poorer or comparable record 20 years back are today much ahead of India

Table 2

The doctor-patient ratio is around 1:2500 (compared to less than 1000 in developed countries). The disparity is brought more sharply into focus when one considered that while the ratio is about 1:1000 in urban areas, it is less than 1:10,000 in the rural areas.

The extent of callousness in the approach to health can be seen from the table below giving comparison of the percentage of government allocation on health:

Table 3

### **Inadequate Health Care Delivery System**

Even these meager resources are not equitably distributed, 80% of the resources is spent on big hospital and research institutions, which are situated in metropolitan cities and large urban centres. They cater to less than 20% of the people. On the other hand just 20% of the resources is spent on primary health care, which caters to cover 80% of the people.

The result, as the draft plan itself states, "In the modern development of health services is the irrefutable fact that the system waits for sickness to arrive and in any even provides more medical care to some than primary health care to all. Thus the man-woman differential, real as it is, is compounded by the costly irrelevance of the modern health system to the needs of the masses."

Why then does the perspective plan refuse to make a commitment to greater allocation for primary health care. For without this, all talk of achieving better primary health care for women and "reversal" of the prevailing situation becomes mere empty phraseology.

A major problem of health care for women is the problems of child care even where facilities are available. Due to the fact that women are not able to leave their children, they do not avail of these facilities. This is one of the reasons the draft plan states why more men avail to health care although the women need it more. Yet the plan fails to even state this problem, let alone recommend the need for the child care facilities in this area.

### **The Primary Health Care System**

It is a universally recognised fact that the Primary Health Care System has to be strengthened if the devastating figures, particularly of maternal mortality are to be brought down. The draft plan itself states, "Recognising that the renewal of the human race is the unique contribution that women make at considerable personal cost to the nation's existence and productivity it must be taken as a national obligation to ensure that the fulfilment of this role occurs with minimum personal risk to women's lives and health. For such a statement to be elevated to an actual plan-the first prerequisite is naturally greater resources. As the annual report of the Ministry of Health and Family Welfare (1987-88) very candidly states, "because of the resource constraints, only 50% of the Community Health Centres would be established by 1990. In other words the targeted (leave alone the actual) coverage of the PHC system by 1990 is just 50%. This is just not enough. It seems that despite all claims, in real terms to the planners, the lives of lakhs of women who today needlessly, is expendable.

More allocation needed is the first aspect and its proper utilisation naturally forms the second. Here, according to the latest report of the Comptroller and Auditor General (CAG), the numbers, of beneficiaries under the Supplementary Nutrition Programme has declined from 61,000 in 1980-81 to 40,000 in 1985-86, The CAG report for the year ending March 31, 1981 has criticised the functioning of three major programme i.e., Blindness Control Programme, Tuberculosis Control Programme and Leprosy Eradication Programme. These programmes have been rendered improper due to non-utilisation of funds, non-release of sanctioned funds, and lack of planning and monitoring of these programmes. Such is the fate of the vertical health programmes.

The principal problem with all the health programmes in operation has been a total lack of community participation and the consequent absence of accountability to the local community.

The draft plan has pointed towards the efficacy of some programmes in the voluntary sector due to community participation but has failed to take this lesson for the entire PHC system by recommending that it should be made answerable to local bodies.

### **Family Planning**

A part from the issues raised above, one of the major problems for the PHC system has been the heavy burden imposed on it by the family planning programme with its terrible fetish targets. There can be little doubt that today the family planning programme is being pushed by the Government at the cost of health, particularly of women.

Expenditure in this area has increased by leaps and bounds. From a meagre 0.14 crores in the Ist Plan it went upto 409 crores in the 5th Plan, 1426 crores in the 6th Plan and finally to a proposed 3256 crores in the 7th Plan (equaling the outlay on health of 3392 crores).

While the draft plan seeks to present the family planning, programme as opening the choice of control of their lives and health to women, in actual fact it has virtually become an assault on women. This is evidenced by the fact that accompanying the increase in expenditure, female sterilisations have increased, amounting to almost 90% of all sterilisations. Many of these operations, the draft plan itself admits are being performed without proper care and follow-up, leading to severe complications.

This is not all. The plan itself states the whole propaganda regarding contraceptives and sterilisation is being aimed at women. The result is an adverse impact on women's health, whether due to hormonal reaction to pills, pain and heavy bleeding due to I.U.D. or post operative problems after tubectomy.

Although the draft plan admits that this situation needs redressal, the actual question that has to be asked is whether this huge investment is justified. For, despite the increased investment, the birth rate has remained static at around 33/1000 for the last decade. While universal experience has shown that socio-economic development is the basic condition for a falling birth rate, the Government seeks to hide its failure by attempting to find technological solutions to social problems. And their technology has definitely been at the cost of women's health.

Another example of this is the Government's decision to allow the use of NET-EN as a contraceptive. There is no serious investigation of the risks of such injectable contraceptive in terms of women's health. Yet the Government was prepared to allow it to be used on Indian women and had to be restrained by a Court stay order.

### **Pharmaceutical Industry in the Strangle Hold of MNCs**

Today, the Government has allowed a number of drugs hazardous to women's health to be freely available in the Indian market. The struggle of the women's movement demanding the ban on EP Forte and the reluctance of the Government to do so brought this fact into sharp focus. Here, while the draft plan has made an effort through tardy recommendation regarding the ban on the sex determination test amniocentesis, it is singularly silent on the question of hazardous drugs. Perhaps, this is because while the ban on amniocentesis will affect only medical practitioners, the question of drugs will directly affect the profits of drug corporations, particularly the MNCs (Multi National Corporations).

Today, while there is perennial shortage of essential drugs, useless and hazardous drugs flourish in the market as given in Table 4.

The mercenary attitude of drugs multinationals is responsible for holding the health of the country on ransom. They market drugs in this country which are otherwise banned in their parent countries. EP Forte was but one of them. They use us to test new drugs with dangerous side-effects and in a variety of ways Rout the law of the land with impunity.

There are 60,000 drug formulations in the country, though it is widely accepted that about 250 drugs can take care of 95% of our country's needs. The market is flooded with useless formulations like tonics, cough syrups and unnecessary vitamins while anti-TB drug production is just 35% of the need. While 40,000 children go blind every year due to Vitamin A deficiency, Vitamin A production was just 50% of the target. The production of Chloroquine fell by 50% in 1983-84 at a time when 20% of the people in India are exposed to Malaria every year.

Health related industry has the second largest turnover, world over, after the armaments industry. The predatory nature of the pharmaceutical industry appears now ready to outstrip even the armaments industry. The control of drug multinational companies on the Indian market is almost complete. There are more than 50 MNCs in the drug market in India. Fifteen such companies control as much as 31.8% of the total Indian market. They have earned huge profits while charging exorbitant prices for their products.

Thus, on the one hand an inadequate health care delivery system has forced people to take recourse to the private sector in health care. Health has become a commodity to be purchased in market. On the other hand, monopoly profiteering in the drug industry has ensured that the price is too high for the common women of India.

### **Water, Sanitation, Housing and Women's Health**

While the draft plan has cursorily stated the need for emphasis on the preventive and promotive asserts of health it has failed to either pinpoint responsibilities or methods of bringing this about. An overwhelming majority of diseases can be prevented by the supply of clean drinking water, by providing adequate nutrition to all, by immunizing children against prevalent diseases, by educating women about common ailments and by providing a clean and hygienic environment.



Yet according to the Government's health policy statement (1982) "Only 31% of the rural population has access to potable water supply and 0.5% enjoys basic sanitation".

While the draft plan in the section on support service has referred to how community participation in some areas under the aegis of voluntary organisations has helped to provide water and sanitation, this once again begs the issue for the nation as a whole. For the plan to envisage water and sanitation for all, decentralisation and democratisation is the prerequisite for community participation.

The situation is not much better in urban slums. A recent study conducted by the National Institute of Health and Family Welfare points "the existing health and morbidity patterns in the urban slums is even worse than the rural areas of India." Talking about Delhi the study says, "The most important and common features in three out of four slums are the extremely unsanitary, environmental and hygienic conditions in which the slum population is living." It is in such a context that the recent Cholera and Gastroenteritis epidemic in Delhi must be viewed.

This is the result of the Government's preoccupation with providing extra facilities for a select few at the cost of basic amenities for the vast majority.

Regarding the poor quality of housing, which deeply affects women's health the plan, has no meaningful review. It should be noted here that in the urban areas the slums development policy of the Government has brought into existence lakhs of houses which are provided with almost no ventilation. This indicates widespread disease and poor health as a Government's policy for the future.

Yet the draft plan while noting that all such facilities should be provided, fails to recommend the restructure of the Government's priority in this area, without which the health of the majority of women in the country will continue to suffer.

How such preventive measures can alter the course of diseases is typified by Tuberculosis. Drugs for treating T.B. were discovered after 1940. Yet 20 years earlier, the disease had been almost totally eradicated from Britain due to improvement in conditions of living. But even today when numerous have been discovered for treatment of the disease, more than half a million die of it every year, in India.

### **Women's Work and Health**

It is strange that despite the fact that the draft plan notes that working conditions of the vast majority of women have an impact on their health, it has nothing to say as to what should be done in this area. Whether it is the organized sector or the informal sector- conditions of work are uniformly poor. In the organized sector, despite legislation, maternity benefit for women are not available to many women. And to top it all the Government itself has announced that maternity benefits should not be offered more than twice, This is clearly penalising women for decisions which are not theirs alone.

Further the computerisation process has introduced new health hazards for women. It is known that foetal damage takes place from the exposure of pregnant Women to work on computers.

In the informal sector where, as the plan itself admits highly exploitative conditions exists, health protecting legislations is almost nonexistent. Where in a few sectors some laws exist-they are not enforced. The result, the health of the vast majority of women-already frail, is battered further. The national commission on self-employed women has detailed health hazards in the informal sector where long hours, inadequate wages, exposure to noxious materials, lack of adequate lighting, in sanitary conditions, poor air flow etc., have been pointed out, Yet the draft plan has failed to take cognizance of this.

And all this is in the background of the double load of wage labour and house work. Whether economically productive or not, housework and child care are social contributions of women and the need to ensure that their health is not crippled by further burdening, sweated labour and hazardous conditions of work needs a special emphasis which is absent in the draft.

Thus to sum up, the draft as it stands has made piecemeal<sup>1</sup> recommendations which are not grounded in concrete socio-economic reality. For any tangible changes to take place in the field of women's health, radical redemarcation of priorities in the while health care delivery system have to be initiated. Hard political decisions to greatly increase spending on health care have to be taken. For the Primary Health Care System to function adequately, it has to be made answerable to local bodies. This in turn would require steps to democratize the functioning of the panchayat system and much greater decentralization of administrative and fiscal powers. Wild profiteering at the expense of health must be stopped. To enable women to withstand and fight back health affecting discriminatory attitudes in society, socio-economic policy must change in favour of the exploited majority. In the absence of such measures one can only hope for some sporadic cosmetic changes to take place.

## **Recommendations**

Apart from those recommendations already made in the draft plan and in fact to make them feasible – we recommend: -

1. Greater allocation of resources overall for health care with the emphasis to shift to Primary Health Care.
2. Decentralisation of administrative and fiscal powers and accountability of the Primary Health Care System to local bodies.
3. To ensure that women are able to avail of health care, child care facilities should be made available along with health care.
4. Facilities for periodic check-ups particularly for iron and other deficiency must be made available. For early detection of TB, Leprosy etc. periodic check-ups should also be done regularly in schools.
5. Mobile vans should be used for rural areas.
6. Alongwith sex determination test there should be a ban on all drugs hazardous to health and all the useless formulations that flood the market. All mass sterilization camps should be stopped. Women should not be victim of experiments in Reproductive Technology.
7. Prices of essential drugs should be sharply reduced. If necessary, subsidies for some should be given.
8. Nationalisation of pharmaceutical MNCs and special emphasis on public sector in drug industry.
9. Water, Sanitation, and Housing for the vast majority should be given greater priority. In rural areas provisions of potable water should be taken up on a war footing. Separate public latrines for women should be provided at the village level. And the vehicle can only be decentralized and democratized by concrete planning-particularly in those areas with water and clean public resources problem.
10. In urban areas, slum resettlement programmes should be directed at more than just putting 4 walls on a miserable of land. It should take into account women's need for space small patch and ventilation. Prompt disposal of garbage latrines must be paid special, attention.
11. For an effective monitoring machinery to ensure the implementation of protective legislation regarding work, women's organisations along with T.Us should be associated.
12. Health protecting measures be extended to the informal sector.
13. As the commission on self-employed women has reported, there is a need for periodic check-up of all women working in the informal sector for protection against occupational hazards. Health cards for women workers with this check-up would help control the impact of hazardous work.
14. Efforts should be made to integrate indigenous systems of medicine on a common scientific basis.
15. Provision should be made for more midwives and health workers with a proper infrastructure for their training, work and salaries.
16. Water and air pollution should be controlled with statutory consultative powers in this area being given to local elected bodies.

## **Recommendations**

**National Perspective Plan for Women 1988-2000 A.D.  
Department of Women and Child Development,  
Ministry of Human Resource Management, GOI, 1988**

### **Infancy and Early Childhood**

5.1 Using amniocentesis for Sex determination tests should be banned as in Maharashtra. Practitioners indulging in and abetting such acts should be punished severely and their medical licenses should be revoked.

5.2 Incentives should be considered to encourage parents to have female children. A couple who opts to limit their family to one female child may be given a regular monthly cash subsidy to attend to the girl child's - needs. The amount must be given to the family over a period of time and not in a lumpsum, as this might result in misuse of the female child as an instrument for getting easy money and later to neglect of the child.

5.3 Infants' and small children's growth and development should be monitored by recording their weights and heights at regular intervals. Proper corrective interventions should be made wherever necessary.

5.4 Universal immunization should be enforced to encompass all children.

5.5 Oral Rehydration Therapy (ORT) should be widely disseminated. ORT salts in packed form should be made available at a large scale in order to reduce the mortality from diarrheal diseases.

5.6 The ICDS should be strengthened and priority access should be provided to the girl child. Higher participation of women would also result from expansion of the programme.

5.7 Efforts should be made to bring a qualitative change in the attitudes against girl children. Media should be used for this purpose aiming to get the girl child to be accepted in the family and the society as an equal to the male child.

5.8 Focus is needed on the adolescent girl (12-18 years), so that she attains her maximum physical and mental capacities. It is necessary to provide alternative options to early marriage. This can be ensured by a mix of education and employment opportunities, and enforcement of the law on maximum age of marriage (18 years). The younger girl child needs to utilize health, and education more fully. It has been proposed that the ICDS will also programmes more address this issue in specific areas.

5.9 Adequate nutrition should be ensured for adolescent girls during the pre-puberty and pubertal growth phase to ensure 'catch up' on physical development by providing supplements to deprived groups.

5.10 Health and nutrition education should be promoted to ensure that preventive and promotive measures are adopted. The necessity of safe water, sanitation and personal hygiene also should be advocated.

5.11 Immunization against tetanus and rubella should be introduced for this age group.

5.12 Linkages with basic health care must be developed at the village level in view of the special problems of mobility faced by young girls.

5.13 A massive communication campaign to create widespread awareness of the law prohibiting the marriage of the girl before 18 years and boys before 21 years and generate consciousness on the severe health implications in children and women of such early marriages must be launched.

5.14 The aim should be to implement the present legal minimum age of marriage effectively by creating a social consciousness for the desirability of marriage for girls only after 20 and for boys at 25. Preferential employment for unmarried males and females and priority in other development schemes for such youth, need to be seriously examined.

5.15 The comprehensive school health scheme which is being formulated, should be speedily implemented. Special efforts must be made for the health services to reach girls of the school-going age who are out of school. Each child should be examined and screened at least three times-at primary school entry, before leaving primary school and at completion of high school. Similarly, a girl child out of school should be examined and screened three times - at around 6, 10 and 15 years of age. Screening kits and medicines should be made available. School teachers and non-formal education functionaries should be trained in the required areas of health care. The health programme for school and non-formal education systems should be integrally linked with the general health services,

5.16 It is necessary to impart information about reproductive processes, ways to prevent conception, need for spacing between children, optimum age of child bearing, necessary care for pregnant women and

lactating mothers and small family norm etc. This may be introduced as a part of the regular curriculum in school, colleges and universities. For girls/boys who are not in school, anganwadi workers/female CHWS may impart this knowledge.

5.17 To improve women's health status there is no doubt that the general health services have to be made to respond to women's specific problems. A strategy for improving the health of women in the reproductive age group would be to reduce the risk of death and illness associated with pregnancy itself. Comprehensive minimal care during pregnancy, childbirth and thereafter, steps to ameliorate malnutrition as well as decrease the workload of women, and improved access to health services, particularly family planning services, should be the salient instruments for improving the health of women.

5.18 Since women are severely restricted in their mobility, basic health care services must be made available to them as close as possible to their homes. Therefore, resources should be allocated as a priority to health services at the village, as well as at the first level of referral. The services would be provided by the female health workers, supported by the functionaries and the community from the village, as well as supervisory echelons within the health sector. Measures should be taken to reduce the incidence of low birth weight babies.

5.19 A minimum package of services should be available for pregnant women at village level. This should include at least

- Facilities for early detection of pregnancy, with low-cost pregnancy detection kits;
- Antenatal registration,
- Minimum of three antenatal check-ups in the second and third trimester;
- Screening of high-risk cases;
- Anaemia prophylaxis with iron and folic acid tablets; Tetanus toxoid coverage;
- Prophylaxis against malaria in high endemic areas;
- Advocacy of adequate rest;
- Health and nutrition education;
- Priority attention to locally endemic diseases affecting women; 10 and
- Adequate safe drugs for her illness.

5.20 ANMs should be trained to assess pelvic proportions of pregnant women to identify the high risk cases and refer them to competent institutions. This will help in saving women from maternal deaths and also to reduce the incidence of still births.

5.21 The emphasis will have to be on providing better care to the pregnant woman in her home, as well as to ensure that adequate facilities are available at the first level of referral to deal with obstetric emergencies such as toxemias, sepsis, obstructed labour and haemorrhage. In order to improve village level care during child-birth, the following are suggested:

- Continuous training, supervision and support for better midwifery practices to the TBA and female health workers;
- Provision of sterile delivery kits to the TBA, health workers and even to mothers,
- Stocking adequate drugs and supplies with the health workers and providing a restricted number to the TBA, and
- Pre-arranged transport (or reimbursement of transport costs) for any emergency, when a woman has been registered for antenatal care.

5.22 Post-natal services should be available as close to the homes of mothers as possible. In rural areas in several parts of India, women do not leave their homes for 40 days after delivery. Post-natal care should include:

- A minimum of three contacts with the mother by the TBA and/or female health worker within the first 10 days after child birth
- One massive dose of vitamin A within one month after delivery to all mothers
- Iron and folic acid for 50 per cent of mothers
- Adequate drugs to deal with puerperal sepsis
- Education for the mother's nutrition and contraception as well as for infant feeding and health care, particularly immunization.

### **Women's Health Care**

5.23 The health of women who are not pregnant or nursing, is an area which has received inadequate attention so far. Interventions thus made can cause a significant difference to women's health status pot

only between pregnancies but also improve the outcome of future pregnancies. Moreover, the woman's right to health care as an individual must be promoted.

5.24 Women with chronic or serious illnesses, such as tuberculosis, leprosy, viral hepatitis, anaemia, sexually transmitted diseases, etc; should be promptly treated and advised to postpone their pregnancy for a suitable safe period.

5.25 High priority should be given to women for treatment/ control of all endemic diseases, specially those which have a harmful effect on the next generation (for example, goitre, sexually transmitted diseases, etc.).

5.26 Doctors of the Primary Health Centres be given in-service training to handle the, cases of possessive syndrome and neurosis. Mass education programme be taken up to change the negative attitudes prevalent against mental illness.

5.27 Nutritious foods produced in the villages should be primarily utilized to cater to the nutrition needs of the rural poor. Only the surplus should be allowed for export to urban areas. A wide spread public distribution system' would be essential to make basic foods available at affordable costs.

5.28 Emphasis should be placed on Science and Technology research pertaining to sex linked diseases, occupational hazards, and indigenous methods of family planning as affecting women. Undergraduate level programs should introduce courses relevant to women i.e.:

(i) Work physiology (ergonomics) as related to health, and occupational hazards.

(ii) Basic tenets of genetics, related to family studies, genetic disorders and environmental effects.

(iii) At the postgraduate level and above, research needs to be conducted on ergonomic abnormalities in women such as spinal strain after carrying loads. Also, work is needed on sex-linked, genetic disorders like muscular dystrophy and haemophilia, where women are the carriers.

5.29 More Primary Health Centres should be set up in the rural areas to achieve the target of having one Primary Health Centre for each 30,000 population as recommended by the Bhore Committee in 1946.

5.30 The timings of the dispensaries and hospitals should be fixed in a way which would be convenient to working women.

5.31 There should be a 24 hours creche facility for women patients with children in every hospital and PHC.

5.32 There is a need for a humane Drua Policy and check on the pharmaceutical industry that at present operates on the profit principle like any other industry.

5.33 It is necessary to provide safety equipment including powerful exhausts to remove harmful dust from the work environment and personal protective equipment like masks, feet protectors, eye glasses, ear muffs and gloves and strong contraceptions for the safety of women workers.

5.34 There should be Refreshers/Orientation courses for the doctors on the subjects of women's work and health.

## **Family Welfare**

5.35 Family planning policy should be such that it will help women have greater control over their bodies and enable them to make conscious choices on having or not having children and deciding the number of children they want.

5.36 Injectable contraceptives as well as other contraceptives banned in developed countries should not be permitted in the country.

5.37 More research needs to be carried out to develop contraceptives that can be used by men and they should be propagated more widely.

5.38 Family Planning counselling needs to involve married and older women, selected from local surroundings for effective transmission of the concept and its urgency.

5.39 Laproscopic operations should be followed up.

5.40 Disseminating information about temporary methods of spacing should be accorded high priority.

5.41 Male sterilizations (vasectomies) need to be encouraged.

5.42 Recommended measures in the non-health sectors that critically influence health are as follows:

-Drinking water supply is a prime essential;

-Fuel should be made available within easy reach to all;

-Progressively more latrines should be made available, and their use encouraged by special education efforts aimed at women;

-Energy-saving devices for household work should be actively

promoted for conserving women's energy.

#### FOONOTES

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