Karkal, Malini.: Our Health: How doest it count? In: Our Lives our Health edited by Dr. Malini Karkal. Co-ordination unit. World conference on women - Beijing '95'. Aug. 1995. P. 191.

Our Health: How Does It Count? - An Overview

Malini Karkal

Health Figures What They Tell, What They Don't

For the year 1993 (latest available) Registrar General of India reports a death rate of 9 per 1000 population. World Bank (1993, p.290) reports the same figure as a death rate for the countries that the Bank classifies as high income economies (HIEs). These figures show that the death rates for the countries belonging to HIEs and for India are the same. However it is important to realize that the health conditions in the two are not the same. To understand the relationship between health and death rates one needs to see, not just the number that dies, but 'who' dies. Among these are the age and sex differentials in the deaths. For example, the infant mortality rates (IMR) or the deaths in the first year of life, for India was 90 for 1000 births. Whereas that for HIEs it was 8. (World Bank, 1993, p.292-293) Same is true for death rates for other ages, for the two sexes and for that matter, deaths such as maternal deaths, calculated as the maternal mortality rate (MMR).

In HIEs, aged populations contribute a larger share to the total deaths. In contrast, in India it is the young that account for the large proportion of the total deaths. As a consequence, the populations in India, when seen as distribution by age, show a continuous decline as one passes from one age-group to a higher one and when population is plotted by ages, and for the two sexes on the two sides of the axis, it forms a pyramid. In contrast, in the HIEs there are fewer deaths in younger ages, and as one passes from one age-group to the next the age-sex distribution of the population forms almost a rectangle, till a sufficiently higher age, after which there are deaths to the older persons.

Change in the socioeconomic and other conditions influences the health and results in certain life-conditions. However, it is Incorrect to assume that observed conditions indicate similar changes in health situation of different people. Indicators such as Crude or Adjusted Death Rate, IMR (Infant Mortality Rate), MMR (Maternal Mortality Rate), Life Expectancy at birth, standardized mortality ratio etc. are used to measure the health situation of the people. However it must be realized that while improvements as indicated by these indicators are suggestive of overall improvements, yet they must be used with great caution

when discussing the changed health conditions. These indicators have imperfect association with health, either on the individual or the aggregate level. As an example, one can see the data of Life Expectancy. At the ICPD (International Conference on Population and Development) held in Cairo in September 1994, wide publicity was given to the information on life expectancy and the TFR (average number of children a woman bore in her life time) of all the populations in the world, trying to indicate that lower the TFR higher the life expectancy. This was attempted even when, as expected, the data did not support this relationship.

Experience in mortality of the developed countries shows that over two-thirds of the decline in mortality, in these countries was achieved before modern medicine became available. This decline was mainly achieved because of improvements in the environmental sanitation and personal hygiene. These changes reduced the incidence of infectious and parasitic diseases, especially those that were caused by polluted water supply and food. Simultaneously, the improvement in transportation helped in distribution of agricultural yield to areas of famine, reducing deaths due to malnutrition. Modern medicine helped to conquer the remaining one-third deaths.

The changes in mortality in the developed countries benefited the children whose chances of survival increased greatly. In contrast the gain in lifespan of, the older age groups, was much lesser. Mid-nineteenth century, one-fourth of the children born died by age ten, whereas by age 45 about half were dead. The decline in death rates of the developed countries was achieved in about a century from the second half of the nineteenth to the first half of the twentieth century. The decline in mortality in these countries was a product of social, technological, economic and political change. With improved chances of survival of children, women bore fewer children without programs to control fertility or even inspite of opposition to prevent births.

The Indian Experience

Indian experience shows that in 1940s large scale programs were launched to control selected infectious diseases through the use of powerful insecticides, vaccines and antibiotics developed during 1930s and 1940s and produced mostly in the industrialized countries. These programs initially did show results. However, interventions dissociated from broader economic and social change and by programs that leave intact the social and cultural barriers have certain limitations. It was observed that the disadvantaged groups in the society benefited far less than the advantaged ones. Generally the official policies led to increases in the GNP without changing the income distribution. Agricultural reforms such as Green Revolution forced small land holders to sell their lands

and either become landless laborers or migrate to urban areas to work as casual laborers or take up low paying jobs. There was an increase in the chronic malnutrition for the landless and the urban poor. Studies in Bangladesh and Sri Lanka have shown that in the times of hardship there is sex and age selection and the women and the children are victims in larger numbers. (Ruzicka and Hansluwka, 1982)

In India, death rates for the infants and the children had stagnated for many years even when life expectancy had shown an increase. Introduction of programs such as immunization and ORT (oral rehydration therapy) saved lives of many children and showed declines in IMR and child deaths. However, in many cases, it was only postponement of deaths or a survival without, much of positive health. "More and more poor infants and children are now 'surviving' despite continuing poverty, under-nutrition and insanitation, because of 'death-control' strategy. Thanks to the false leads of international agencies." "There is no evidence that severity of growth retardation and. underdevelopment among poor children has significantly declined. In short, there is, a progressive erosion of the quality of our human, resources in view of the expanding pool of substandard survivors" (NFI Bulletin 1991) A look at the age specific deaths over years shows that their contribution to life expectancy is because of such survival of the young and improved chances for those in older ages.

The Indian data also show wide disparities in health status of populations when seen by different characteristics such as sex, rural/urban residence, occupations, the State of residence etc. When health condition is poor there is wider scope for differences in achievements of different groups in the improvements in health. While Kerala shows far better health for its people, the BIMARU (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) States still show poor health situation. A look at the development indicators shows that there are also wide disparities in achievement of the social indicators such as education-and especially for women, economic development and extent of unemployment, industrialization and urbanization etc. When trends over time in the development indicators are seen it becomes clear that all States have not had progress that followed similar pace. BIMARU States were comparatively much better in the earlier years of the century. However, the progress in later years was rather poor. Sex ratio in States such as Bihar favored women in the initial years of the century. It was only later that the sex ratio showed declines and became favorable to males. (Karkal, 1991b) It can be clearly shown that there are closer links between distributive justice wherein all sections have access to gains in the progress and social development and improvement in the life of the people including the improvement in health. There is a need to look at the conditions of all sections of people rather than judging the impact of development as averages. Averages most often mislead since they overlook distributive justice.

The discussion on health must begin with the WHO definition of health which defines health "as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." Incidently, analysis of the health situation of the people points out that over medicalisation of the health problems may show improvement in the survival rates of the people. However, this promotion of the interests of the medical profession and the pharmaceutical industry has played a major role in denying people better health. It therefore needs to be pointed out that the role as well as the consequences on the social and mental conditions of the people must be seen to understand the physical well being of the people. In that sense perhaps the ordering of the words in the WHO definition needs to emphasis social well-being that leads to better mental and physical life of people.

Figuring Out Women's Health

In discussing women's health it has to be realized that women are exposed in the same way as men when the discussion is about prevalent problems such as tuberculosis, pneumonia, bronchitis, fevers related to malaria, typhoid, gastroenteritis, etc. Since women's illnesses get attention much later, if at all they do, and they are likely to be treated at home rather than by a doctor or at a medical center, women are more likely to face serious consequences including death. Women are also different as a result of their biological and physiological make up. Since anaemia is more prevalent in women, blood-depleting diseases like malaria affect women's health more. Because health is influenced by political, social, economic and cultural conditions, there are differences in the health conditions and health needs of people belonging to different political, social, economic and cultural settings. The discussions on the health of women therefore must take into consideration the hierarchial and patriarchal nature of the society as well as the economic and health policies and the changes in them over time. Unfortunately, the official policies have never considered women's health needs, excepting their role as producers of children. And hence the only program that is included in the health services, that caters to the needs of women is the MCH (maternal and child health). And even in that there is greater emphasis on "C" than on "M".

The National Health Policy laid in 1982 had goals of reduction of mortality. The policy did not have separate goals for the males and the females. IMR was to be reduced to 60 by 2000, death rate to 9, MMR to under 200. All pregnant women were to receive ante-natal care and all deliveries were to be conducted by trained birth attendants. Tetanus immunization was to be 100 per cent of the pregnant women and the school going children. Vaccinations DPT, Polio, BCG, DT were to be 85 per cent of the relevant groups. These were to raise the life expectancy for both sexes to 64 years by 2000. As the data show IMR, MMR continue being

higher and neither the targets of attendance at delivery nor the immunization are anywhere near the laid down goals.

The policy does not indicate goals for reduction in mortality by age or for that matter by sex. IMR for 1990 was 80, which is higher than the goal for 2000. More important is the fact that in recent years both infant and child mortality have shown a decline but there has been minimal decline in neonatal mortality, and there are wide disparities in the gains when achievements for the two sexes are seen, indicating that the major cause of infant mortality, In India-poor health of mothers, as well as the attitude to girls, is not corrected by the program.

The differentials in mortality in rural and urban populations are large. IMR in rural areas was 52 per cent higher and child mortality was twice as high. It is important to note that inspite of reductions in IMR and child mortality, 1 in 8 children die before reaching age 5. Larger proportions of these are girls. With the neglect of women, MMR continues to be high. NFHS (1993) data show that MMR in rural areas is 420 and in urban areas it is 380.

Further, over-importance to population control has led to the promotion of the family planning program, completely neglecting the health needs of the people. (Banerji, 1983) In the patriarchal and the hierarchial society this approach has led to oppression and neglect of the women and the marginalised sections of the society. Since women form a larger proportion of the marginalised, they face double neglect of their health needs. History shows that even before the terror of forced sterilization unleashed during emergency, India had Lippes Loop that came with the PL-480 wheat in the 60's. These were inserted into thousands of rural women and the women were left to suffer bleeding, serious back pain, cramps etc. To begin with inserting IUDs into women when reproductive tract infections are high, is inviting PIDs (pelvic inflammatory diseases) that cause suffering and infertility. There is adequate evidence to show that political compulsion always got priority over women's needs.

Society, Women and Health

Segregated and asymmetrical gender relations are present not only in discriminatory treatment meted out to daughters in the family but they are strengthened by the marriage practices. Marriage is riot seen as a union of two equal individuals but is an alliance of patrilineal kin groups. Early marriage to a man senior in age, practice of village exogamy and patrilineal residence upon marriage ensure that women submit to fulfilling traditional gender roles. Under such situation women's problems are defined in terms of families needs rather than their own unequal access to resources. (Karkal and Rajan, 1989)

Early marriage not only denies a girl the years of growth and development, but it is harmful to her health. Inspite of legislation preventing early marriage, data show that the percent of the girls who are married and are in the ages of 15 to 19 years varies between 3 in Goa and 64 in Madhya Pradesh. The percentages for the rural populations vary from 35 (Goa) and 73 (Madhya Pradesh). (NFHS, 1993) It must be added here that over years the age at marriage of girls has shown a rise. However, it is mainly the postponement of the marriage ceremonies in children under age of attainment of menarche that is responsible for the rise in the figure. Earlier, the marriage was followed by a ceremony of Gauna after which the marriage was consummated. Gauna was celebrated soon after the girl attained menarche. It is seen that currently the girls start their married lives around their age after menarche and in the sense of being exposed to early sex there has been very little change. (Karkal and Rajan, 1989)

Child bearing starts early, is supported by the data on age specific fertility rates (ASFR) or the number of children born to 1000 girls in the age group. NFHS (1993) reports that the ASFRs for ages 13-14 vary from 0 in Kerala, Meghalaya, Manipur, Mizoram and Himachal Pradesh to 25 in Karnataka, 22 in Assam and 19 in Maharashtra. For ages 15-19 ASFRs vary from 16 in Goa, 30 in Manipur, 38 in Kerala, 130 in Karnataka, 144 in Haryana and Andhra Pradesh and to 153 in Madhya Pradesh. Age at marriage in India varies between 12 and 14 years. A girl requires atleast 6 years before she is physically mature to bear the burden of pregnancy. (Royston and Armstrong, 1989) It therefore is obvious that the girls married before age 20 are at risk. Physical immaturity of mothers also affects growth and development of their children and explains high incidence of maternal mortality and morbidity and low birth weight babies seen in India. Number of children that women bear during her life span or the TFR (Total Fertility Rate) has shown a decline from over 5 in 1971 to about. 3.4 by 1992 (NEHS, 1993) Though this may indicate a decline in child bearing of the women what needs to be seen is that much of this decline has been achieved by the declines in child bearing of women of older women. Fertility in younger ages continues to be high. So the achievements are due to the (forced) sterilizations and not the social change in attitude to girls and their child bearing and their being able to decide to have fewer children. It also must be pointed out that child bearing among the young is not only indicative of the physical problems of motherhood at these ages but it is also a proof of girls being denied development opportunities during their adolescent years.

A statistically significant relationship was found to exist between adequacy of the maternal diet and the course of pregnancy. Eclampsia takes a large toll of maternal and infant lives and is responsible for 2.2 percent to 10 per cent of maternal deaths in India. No instance of preeclampsia occurred in women whose diets were 'good' or 'excellent'. But about 50 per cent of mothers with 'poor' and

'very poor' diets had toxemia. 'Poor' and 'very poor' women also tended to have more difficult labor and more major complications at delivery, inspite of the fact that on an average, they had smaller infants. There was also a relationship between prenatal nutrition and major complications of the postnatal period. Incidence of stillbirths, neonatal deaths a marked malformations at birth as well as LBWs and functional immaturity was higher in 'poor' and 'very poor' mothers. It is therefore seen that poor nutrition during pregnancy affects foetus more profoundly than it does maternal organism (Nutrition Reviews, 1948, pp. 386-387). It is observed that by ages 24 to 59 months as many as 65 per cent of the children are having in ages 12 to 23 months 27 per cent are found wasting. There are virtually no such cases in the HIEs.

It is found that 88 per cent of the pregnant women suffer from anemia corresponding to about 15 per cent in HIEs. Anemia not only increases the chances of contracting infections but in cases in women it increases the chance of having problem's in pregnancy, as well as delivery. Babies of such women have greater health problems. Recent research also shows that higher incidence of diabetes and cardiac problems reported in India, is also rooted among the survivors of these low birth weight babies. "The major nutritional concern in India are those related to maternal under-nutrition, high infant and child mortality, impaired growth and development of children and rank under-nutrition." (NFI Bulletin, 1988)

Jeevanjot describes the kinds of problems that are at the root of women's bad obstetric experiences and how to deal with them. The origins of these problems are far more deeply rooted in the poverty and discrimination.

Studies have shown that there is an increasing gender gap with improving socioeconomic status. Poverty alleviation programs are of little benefit to girls. A study in Tamil Nadu showed that the gender disparity in under-nutrition was worse in comparison to pre-project.

Since patriarchy operates on age and sex hierarchy, aging improves women's position in the family and therefore older women support patriarchy. The roots of mother-in-law problems therefore lie in the patriarchal structure of the society and not in the 'women are women's enemies'. Women derive economic security and social identity through marriage and subjugated roles of women. Sexual stratification provides strong pro-natalist pressures for women. Sons represent not only social security, but the birth of sons improves the status of women. Older male family members receive greatest material advantage in having large families while women improve their status by having many children. Age-sex hierarchial powers of individuals extend beyond the physical presence of the members of the extended family. Consequently nucleo-local families still show

influences of the decision-making powers of the members of the extended families. This leads to several stressors that cause several moderate to severe mental health problems in women. Bhargavi Davar's study for Anveshi' - a women's research center, found that "where mental illness has, a psycho-social basis, women are far more frequently ill than men".

Men's control over valued resources and women's sexuality makes women dependent and powerless in decision making. This results in women's confinement to familial roles that revolve around reproduction, prestige for which is also derived from production of sons. Knowledge about sexual matters and initiative and decision making in the matters related to sex is the male prerogative. Only through begetting sons can a young wife find herself fully incorporated in the husband's family. Childlessness is viewed as the greatest curse and a failure to bear male child is only a little less tolerable. Residence alone markedly understates the prevalence of extended family. Women bear triple burden of reproduction, domestic work and productive labor.

It is observed that out of 10 children found to have had normal nutritional only 3 happen to be girls. Remaining 7 were boys. Deterioration in nutritional status is observed as girls grow older. Throughout their lifecycles women receive less food than men and also of 'inferior quality' foods. Starting with breast-feeding, girl infants receive less milk, less frequently and over shorter duration than boys. A study showed that on an average, male children were breast-fed for 5 months longer than the female children. This practice has cultural roots, rather than economic conditions of the family, is established by the findings of the study that among the richer classes boys were fed for 10 months more than the girls.

Lesser quantity of food intake as well as food of poorer quality such as less quantities of protective foods like pulses, leafy and other vegetables, fruit, milk, oils, fats and flesh foods including is known to affect -growth and development of the girls. It is now well established that poverty is not the only cause for malnutrition. Data also show that unequal distribution assures men in some of the poor families to get adequate food. Studies in States such as Punjab, where there has been considerable agricultural growth and economic development, show that gender differentials among landed families are higher than the landless ones. Selective discrimination among the sexes is practiced against second or higher order daughters, particularly among the better-offs who aspire smaller families. So the demographic transition that is reported for the region-has worsened the status of the girl child. The' State of Tamil Nadu where the position of women was always reported to be better than that in many of the Northern States, now report female infanticide as attempts to limit the family size under the current promotion of family planning.

Structural Realities and Women's Health - The Economy, State And The Health System:

Studies in West Bengal have supported the belief that even development programs distribute the gains unequally between the sexes. It was found that following the land reforms the percentage of households owning land in rural areas increased and mal-nourishment among children under age-5 decreased. However there was a sharper differential between the sexes. The boys gained considerably but there was no difference in the nutritional levels of the girls. In keeping with the societal attitudes it is observed that in times of extreme food scarcity, girls suffer more frequently tom malnutrition-and from death.

Population control programs have not dealt with patriarchy that demands women to achieve status through reproduction and, through begetting sons. Nor has it empowered women to take decisions in the matters of their bodies or for that matter in their sexuality. On the other hand, by forcing on women the long acting and provider-controlled contraceptives and oppressing them with the objective of controlling the size of the population the program is reinforcing patriarchy. Under these conditions achieving fertility control has been seriously threatened. The achievements in the family planning are therefore not in keeping with the demographic demands. There has been promotion of the idea that improvement in the survival of the children may lead to greater acceptance of a small family norm. With this development a program of Child Survival was launched. Similarly, realizing that the maternal mortality in the country is disgracefully high, there was a launch of the Safe Motherhood Program. Currently both these programs are being promoted. As expected there has been very little improvement in the situation with the mothers or for that matter of the infants and the children. IMR and child mortality continues to be high and deaths of the young form the largest share in the total. And this does not discuss the quality of life of the survivors. What has to be understood is that the M and C must go together. Reduction of IMR to 60 per 1000, which is the aim of the Health for All programs, cannot be achieved when the expected MMR in the same program is 20 per 1000. There is a need to have an MCH program that monitors the links between the health of the mothers and their children. (Karkal, 1985)

Neglect of women's health needs has continued inspite of the fact that time and again; several committees have looked into the health conditions in India and have recommended policies for modifications and improvements in the health care. (Karkal, 1991a) As said above, even the National Health Policy does not provide for the health needs of women. Duggal presents details on the health scenario and provides information to show that the services are inadequate to cater to the needs of the people and the geographic distribution of the services,

with biases in favor of the rich and the urban areas, ignores the needs of the large section of the rural and -urban poor. Bhatt supports Duggal and lists how Women are unable to avail even whatever services that are provided because they are inadequate and not designed to meet the requirements of the women. Duggal also points out the deficiencies in the functioning of medical professionals who are largely concerned with profits for themselves than the improvement in the health of the people. It is critical to note here the way traditional and folk systems of health care which are the mainstay of medical support to thousands of poor people in remote rural areas, have not seriously been promoted and not much structural support has been afforded by the states to traditional streams of medical care such as Ayurveda, Unani and Siddha. The Shodhini Team has in its micro level multi-spatial study reveal how women's knowledge and skills in folk health and herbal cure can make health accessible, affordable and lead to women's control over their bodies.

Women bear a heavy burden due to their role in reproduction. It is for this reason that a program that regulates fertility and provides opportunities for women to improve their health is welcome. However, the way the family planning program functions, it has not helped in improving the health of the women. The program has never been promoted as a program that will improve the health of the women, and especially since the Fourth Five-Year Plan it has had the objective of population control. Forum presents the description of the family planning program and how it is promoted. When there is a need to reduce medicalization of the women's bodies and to empower them to get control over their bodies and over their sexuality, the program is promoting, the interests of the pharmaceutical industry by introducing newer methods even when they are harmful to the health of the women. Forum also points out that to achieve the objective of population control, the research to promote long acting methods that can be provider controlled, there is no hesitation in flouting the moral and ethical principles laid down for guiding research. It needs to be noted, that simpler and effective methods of contraception which could be controlled by the users, are disappearing from the market, especially from the government operated health services, that are the major sources of supply to the rural areas and the poor.

Since demographers are not happy about the impact of family planning on the birth rate in the country, a new objective, of reducing the women in the population, was suggested by introducing NRR 1 as an objective of the program. NRR refers to the number of daughters a mother will have. Restricting the number of daughters to one is expected to limit the number of women in the population and thereby limit the child bearers. (Karkal, 1986)

Since women have always been interested in regulating their fertility, pharmaceutical industry has a large ready market for the methods that it wishes

to promote. There is adequate evidence from the work of those working with the people that a lot of coercion is used for promoting long acting, hormonal and hazardous methods of contraception. Amartya Sen (1994) comments, "Imposing birth control on unwilling people is no longer rejected as readily as it was until quite recently and some activists have pointed out to the ambiguities that exist in determining what is or is not 'coercion'. Talking of the Indian program Sen further adds, "(such coercion) is not limited to an explicit use of legal coercion or economic compulsion, since peoples' own choices can be overridden by simply not offering them the opportunities for jobs or welfare that they can expect to get from a responsible government."

The level of illiteracy in the population, and especially among women, is used as a criteria for measuring the level of intelligence and an excuse for promoting control by the providers of the services. And this is being done inspite of the evidence of remarkable achievements of Green Revolution that was the result of the work of the same illiterate people. Sabala and Kranti in their article narrate their experiences with rural women and show that self-help in handling women's health problems is welcomed and well accepted by the women. Self-help approach reduces the medicalization of natural body functions of women such as menstruation, pregnancy and delivery as well as menopause. Self-help program improves women's knowledge of their bodies and empowers them for gaining control over their bodies and their sexuality.

Jesani and Iyer describe how in passing the MTP Act, that makes abortions available, has had interests of the medical profession as a guide rather than the reproductive rights of women. Superficially, it looked that in initiating the process of passing the MTP Act the government was supporting the reproductive rights of the women and was helping the needy women. The feminist movement in India had never made abortion as an Issue among their struggles. Jesani and Iyer point out that in passing the Act major promoters were demographers and the medical profession. The Act has, given the control of the situation to the medical profession and their interests have been well protected whereas there remains a threat that the provisions in the Act can be changed to the detriment of the interests of the women.

Again the experiences in the area of abortion shows that the program started with the wrong objective of bringing about a demographic impact has not been able to reduce un-therapeutic abortions. One has no information on the actual incidence of induced abortions. NFHS (1993) which collected data from 98 per cent of the Indian population and the data collection was done by well-trained and adequately supervised investigators, shows that the percentage of total pregnancies that are terminated by inducing abortions varies from 0.3 in Bihar to 4.3 in Tamil Nadu. It also shows that in each State the percentage is higher in

urban areas in comparison to that in the rural areas. One has no way to know about the accuracy of these figures because collecting data on subjects such as induced abortions requires special inputs over and above the qualifications and training of the staff. Even the research design, has to be different from the one that is used for other demographic data. However, the data do indicate that large numbers of pregnancies are terminated and women have health problems.

Indian data show that there is an increase in life expectancy over years (from 26.9 to 60.7 years for males and from 26.6 to 60.1 years for females from decade 1921-1931 to year 1990) These data do indicate improvement in the chances of survival over years. However it does not show comparative improvement in survival at younger ages. Nor is it Indicative of the commensurate improvement in the health of the people. States like Maharashtra, Karnataka etc. show that in contrast to the earlier years, women have higher expectancy than men do in those States. And yet, even in these States the achievements are mainly for older ages than for the younger ones. (Karkal, 1987) This has greater significance because health programs are expected to benefit younger more than the older age groups. And the data shows that this is not happening. Survival shows in higher ages is more a result, of use of medical technologies than the improvements in the life conditions. Also, the fact remains that higher mortality in younger ages shows that the survivors may have managed to survive but do not necessarily enjoy good quality of life. Poor health for young women has serious consequences when they are required to perform their productive and the reproductive roles.

Fatality rate or the death rate, from a specific disease may be reduced through effective treatment (for instance, rehydration therapy of diarrhoeal cases) and incidence of other diseases may be largely controlled through immunization and vaccination (e.g., pertussis, measles, neonatal tetanus, tuberculosis), and yet health may not be improved to the extent commensurate, with mortality decline. Intervention programs against the killing diseases may have no comparable effects on the disabling crippling diseases which, unless their fatality rate is very high, are largely left out of the picture established by mortality rates and their change. It is even likely that the prolonged social, economic and individual burdens imposed by the crippling and disabling diseases may be heavier than those of the killing diseases. Maternal mortality though very high is lower today than what it was earlier. Modern technologies such as cesarean section may have helped some women to survive, but it is noticed that about 17 per cent women suffer serious damages to their health as result of maternity. (Dutta, 1980)

The fact that Indian women have 6 pregnancies during their lifetime in contrast to 1 or 2 in HIE's increases the probability of suffering due to maternal causes amongst Indian women.

Like the populations in the HIES, those in India are also showing increases in the proportions of the aged. Again, there are features about the aged in India, that are distinctly different from those of the aged in HIES. As discussed so far with the medical technologies contributing a larger share to the chances of survival, the quality of life is poorer for the elderly in India. Breakdown in the traditional families has left elderly without any help and support. A poor health service also means greater neglect of the marginalized sections such as the rural, the women and the poor, and all these form a majority. With large sections of populations being, in the unorganized sections of the labor, the elderly find themselves without any support. Women are in larger numbers in the unorganized sectors, and in the rural populations. Their problems therefore are larger.

Lal in her article describes the problems of the disabled. The problems of the disabled women are further compounded by there being women. Social attitudes to women are reflected in the intolerance of the handicapped status and even normal body functions of such women are dealt with harsh measures as was observed in cases of sterilization of institutionalized mentally retarded young girls.

Health of populations in India is poor. It needs to be realized that health conditions of a population are the result of the prevailing socio-economic conditions. As indicated above, death rate, per se, does not give a real picture of the situation. Further, the health of the population is also at the root of the socio-economic conditions, because, productivity in the labor force is very much related to the health of the people. Women's lower status not only affects their share in the resources such as food, but it is seen that their productive roles are hardly recognized. It is known that about 30 per cent households are dependent on women's labor and in another 30 per cent women are the major earners. And yet official census data report barely 10 per cent to 11 per cent women as economically active. This is not merely a question of being recognized for the labor, but, what is observed is that women get very little attention when it comes to getting resources or training for improving their work capabilities. It is also noticed that planning that improves the work conditions or, the work efficiency, cater to the needs of men, completely neglecting the needs of women. Majority of women work in agriculture. They are not only relegated to the roles as a laborer but there has been hardly any effort to lessen the burden of jobs such as weeding, transplanting etc. that are women's jobs. Gothoskar points to some of the occupational health problems faced by the women.

Health, therefore, must be seen in a holistic way. Health is a major issue that needs an urgent attention from the point of improving the quality of life of the people. Unfortunately population policy has all along concentrated on numbers. It is known that babies born with low birth weight -LBW- (birth weight 2500 gms

or less) have poor future. They form larger proportions of the school drop-outs as well as being poor in their productive roles. The fact that around 36 per cent of the Indian children are LBWs, has found no place in the population policy. Other evidences of the neglected quality aspects are observations that are currently reported from different parts of the country about malnourished children, reappearance of diseases that were believed to have been either eradicated or very much conquered etc., are effects of these gross neglect of the quality aspects in the population policy.

Poverty, economic conditions as well as lack of knowledge and an unhealthy environment, is reflected in the poor health status of the population. Over years communication technology is bringing people together and it is now accepted that development, goes much beyond economic growth. Social justice, respect for human rights, and distributive justice, are some of the fundamentals of strengthening a civil society. The data presented by Karkal on PQLI-an index developed to measure the physical quality of life, and not just money power, shows that over years the gains have been poor and distributed very unevenly, over States, over rural/urban areas and between the sexes. States like Bihar, which are now grouped as BIMARU compared well in the earlier years of the century with the States like Kerala, whose example is often sited while enumerating success stories in progress. A look at the trend in PQLls over time, in rural/ urban areas and between sexes indicates the impact of planning of the development programs. The results clearly show the urban and the male biases in planning. They also show that the protection of the interests of the weaker sections has been very much uneven over the States. States such as Kerala show better distributive justice, even when the State reports far lesser GNP and the economic gains, especially when compared with States such as Punjab and Haryana. Low TFR in Kerala was achieved inspite of relatively lower CPR (Couple Protection Rate) and obviously was not solely a result of promotion of family planning program. On the education front it is seen that the achievements in Kerala in literacy were always better than those in other States. When the level of literacy in Kerala was as that is observed today in the other States, level of literacy among females was the same as that of the level seen in other States. As is observed in all areas when the level of achievement is higher, the differentials narrow. When the literacy level of the population in Kerala showed significant rise the differential in the levels of literacy of the two sexes narrowed. Often stated higher level of literacy of Kerala women being an indicator of their better status in the society and reason for participation in the social programs is not supported by a careful study of the situation. Kerala women do not enjoy status equal to that of men in Kerala and they do have problems of lower status and this fact is well documented. (Karkal, 1992)

The arguments made here will further show that the health of a population is largely dependent on the health of the women. And the health of the women is intimately linked to their status in the society. 'Sex' refers to the biological attributes of men and women, whilst gender' is a social construct, referring to the distinguishing traits, attitudes, feelings, values, behaviors and activities that society ascribes to the two sexes on a different basis. Powerlessness of women makes them suffer injustice of being denied the right to health. Violence against women foeticide, infanticide, sexual abuse, rape, battering and bride burning is also a health issue and must be so dealt. Salem points to the plight of the women in the NorthEast and their victimization in the social context that exposes them to higher risks in contracting AIDS. The fact that northeast has greater exposure that promotes conditions that invite's AIDS compounds the problems of women. Women in these areas are exposed to unprotected sex and to work as sex workers.

A society such as India has developed a 'culture of silence', wherein the women not only suffer in silence but they do not take recourse to curative measures and consequently continue suffering. Available data indicate that about 80 per cent to 90 per cent women suffer from reproductive tract infections. This happens because of the overall poor hygienic conditions and women having lesser access to better life and being exposed to higher chances of contracting sexually transmitted diseases. A man may or may not contract sexually transmitted disease from a single intercourse but a woman cannot escape infection from such a contact because she is exposed to the infection for a far longer period. It is also true that under the Indian situation a woman cannot refuse advances of her partner even when she has the knowledge that he is infected. In contrast mere suspicion on the part of the male can throw the woman out. This not only increases the risk for the woman but she tries to hide her problems whether existent or suspected.

Reproductive tract infections not only result in backache, abdominal pain, bleeding, white discharge, etc. but they increase the chances of foetal wastage, perinatal mortality low birth weight babies and higher neonatal and post neonatal mortality. Such losses of pregnancies and babies lead to higher demand for repeated pregnancies and greater risk to the life of the woman.

Health conditions in one phase of a woman's life not only affect subsequent phases in her own life, but they have greater impact on future generations. This intergenerational link is a characteristic unique to women. CHETNA gives details of the problems of growth and development suffered by the adolescent girls. Adolescence is perhaps the most neglected period of a woman's life. Nature has ways of helping. It is seen that girls who are poorly nourished, experience lower growth rate during their adolescence in comparison to the girls who are

better nourished. It is therefore important that poor girls are helped for better growth and development. 'However, the health services do not provide any room for the needs of the adolescent girls and the patriarchal society that wishes to keep women under social control marry them off when they are quite young. Early marriage and child bearing affects young girl's health far more than expected. And, as said earlier, their children suffer in a much larger measure. Seeing this fact it is obvious that among the measures to improve the quality of people postponement of the age of marriage of girls must get priority. Family planning program of today is targeting the TFR without seeing that the contributions to the reductions in the TFR are made by the older women-and not the young.

Jiwanjot points to the problems faced by women in pregnancy and delivery that are rooted in the health conditions of the young women. Low birth weight babies are born to mothers who are too young or too old or those who have problems with their health. Jiwanjot points to the need of attending on the health of the mother to assure healthy babies and healthy future generation.

In planing for the health of women it needs to be emphasized that considerable caution has to be used in applying lessons learnt from the experiences of the populations in the developed countries. To cite examples, in many of these countries there have been movements calling for the inclusion of women as subjects in the clinical trials, since the researchers arrive at results based on male subjects, assuming that they are equally applicable to women. In contrast the demand in the developing countries is the opposite 'do not experiment on women', as shown by the article by Forum, experiences has been that the unethical trials of contraceptives use women very freely. Another example can be in improving the nutritional intake of a foetus, in the cultureless context, seems a good idea. But, in societies where malnourished from their childhood, women are generally stunted and their pelvic bones and the birth canal remains small. In the absence of access to modern health services, a large baby can mean death to the mother. Thus calls for providing medical facilities and institutional deliveries. This also points to the urgent need of looking at the nutritional neglect of women, right from their infant-hood. The article by CHETNA (Center for Health Education, Training and Nutrition Awareness) draws attention to the health of adolescent girls and the consequence of their neglect. Growth and development of the girls must include aspects of their socialization that develop self-respect and confidence so, as the girls will assure their rightful place in the society.

Health conditions of women, are closely linked with the conditions of poverty that they live in, their family structure that restrains them from availing of the health services, as well as accepting healthier life-styles and the political power

that empowers them for equal share in the social resources. It is therefore obvious that the social context, in which women live, has to be taken into account for meeting their health needs. This has now come to the understanding of the international agencies, and is adequately indicated by the fact that at the International Population Conference in 1974 the key to improving women's health was advocated to be increasing CPR (Couple Protection Rate-through contraception) whereas 20 years later, at the International Conference on Population in 1994, the key was ensuring women's health and their economic well-being through their empowerment and their rights over their bodies and their sexuality.

Political powers and planning that decides the future of the people has always ignored the marginalized sections of the population. New economic policy launched in 1991 is expected to improve the economic conditions of the people. Experience of the countries that accepted Structural Adjustment Policies have shown that the beneficiaries of these policies were the multi-nationals and the higher economic groups. There was a substantial retrenchement in the organized employment. Women in the organized sectors invariably are engaged in lower jobs and consequently they have been the first to be retrenched. Pandey points the developments in India after the new economic policy was accepted by the government. Since women are responsible for looking after the interests of the family they suffer whether they loose the job or the males in their, families. The new policy has also reduced the investment in social sectors such as education and health. This again affects the schooling of girls and meeting the health needs of women. In the absence of money, women are forced to, look after the health needs of the family members. The new policy has affected unionization and consequently welfare of the workers is affected. There is an increase in the unorganized employment but they add to the exploitation of the workers, majority of who are women, because neither the working conditions are healthy nor are the payments for the work done fairly.

Experiences over years, and the reporting in media, indicate that the violence against women has dramatically increased. There are those who argue that the reporting is not indicative of increase but the result of overall awareness of the problems of women and their oppression and that leading to better reporting of the events. However, it is to be accepted that the reported events indicate that women face very serious violent situations. And, that social attitude continues to victimize women, and, this happens inspite of greater awareness and even greater provisions against such oppression, in the laws. The question that begs answer is, whether there has been a change in the number of cases. Looking at the fact that the oppressors generally get into action when they face a threat to their power, one is led to believe that greater talk about women's oppression and universal opinion talking (atleast supporting when it comes to words) against

such oppression, as well enacting laws and framing rules and programs to change the situation, is likely to have encouraged oppressors to get into action. It also needs to be pointed out here, that the evidence in the cases of sexual harassment of women in the places of work, showed that the harassers were not interested in sexually exploiting the women they were harassing, but, were mainly interested in frightening them and preventing them from putting their best foot forward in their jobs that would help them to progress in-their work status and thus, challenge the men in work force. By presenting the cases of sexual exploitation of young girls in large numbers, Kulkarni points out how criminalization of politics is also leading to sexual oppression of women.

Sex Ratio - Window into Women's Health

Differential mortality by sexes is a major determinant of the sex ratio of a population; the discussion on mortality quite often includes a discussion on Sex Ratio and the role of differential mortality in the determination of the level of sex ratio. Indian data show that the sex ratio of the population has always been unfair to women and unfortunately over years there has been a decline in the sex ratio (from 1972 in 1901 to 929 in 1991). These data do support the overall finding that the Indian women have higher death rates compared to those for the men. However the lowering of the sex ratio over years is not necessarily indicative of the lowering of the status of women over time. General knowledge tells us that today's woman is in a far advantageous situation in comparison to her mother, grandmother or the great-grand-mother. One needs to know a little more about sex ratio and its calculations, to understand why the sex ratio in India has gone down over the years.

Firstly, it is a fact that sex ratio in India and the neighboring countries such as Bangladesh, Pakistan, Bhutan, Nepal, Afghanistan etc. have an exceptional pattern of having fewer women in the population that is not observed in other countries. This pattern is not a result of high death rates per se. Many countries in the African continent have much higher death rates, but the sex ratios in their populations favour women, and not men. Sex ratio is a result of the differentials in situation of the two sexes IN THE SAME POPULATION. By nature, more boys are born than the girls. Sex ratio at birth or the primary sex ratio varies between 104 to 107 boys to 100 girls. So there is an excess of men to begin with. However men, in general have higher death rates in comparison to the women. So as they advance in age, more men die in comparison to the women. With low death rates prevalent in the HIEs it takes a long time for the women to take over the number of men in the population. e.g. in USA till age 50 the sex ratio favours men (and not women). It is in ages higher than 50 that the gap widens and the population has more women than the men. Since the population has significant

numbers of the old, the dominance of women is seen in the total. (pavis, 1981, Karkal, 1991b)

As pointed out earlier, in the populations with high mortality, as one goes across ages, numbers of persons in each age-group show a declining trend. As a result, the younger population forms a larger proportion in the total and naturally what happens to them is reflected in the total. It is observed that, in India, the relative risk of dying between ages 0 and 4 is 11 percent higher for a girl in comparison to a boy. Between ages 5 to 14, this risk increases to 22 percent and-in ages 15 to 34, to 31 per cent. The women in ages 35 and above, are the survivors of the risks that women are exposed to as 'women'. Thus, the women in ages 35+ are a relatively stronger lot. Also, it is observed that there are relatively much fewer women who go for pregnancy after age 35 and therefore very few women face the risk due to pregnancy and delivery at ages above 35.

It should be mentioned here that, large share of any population consists of the young, e.g. in India, about 14 per cent of the population is in the ages 0 to 4, about 28 per cent in ages 5 to 14 and over 30 per cent in ages 15 to 34, all adding to over 72 per cent. Since in ages below 35 females have higher mortality; their proportion in the total population is less than that for the males. It, therefore, becomes obvious that the young influence the overall picture much more than those in the older ages. Since females have higher death rates in young ages, in comparison to those for males, the sex ratio in countries like India favours males, even when women have better chances of survival at older ages.

In passing, it can be pointed out that sex ratio of a population cannot be used to compare the status of women in two populations. Sex ratio of the population of Maharashtra is 937 (1991) and that of Orissa is 981. (Census of India 1991, p.71) One cannot say that the status of women in Orissa is better than that of the women in Maharashtra. It however does show that the differentials between the two sexes in Orissa are narrower than those in Maharashtra. (The subject needs further discussion to get a complete picture but is avoided here to restrict the discussion to the subject under discussion)

Disability Adjusted Life Years (DALYS) - Women Valued Less

Till recently, no measures existed for measuring morbidity or ill health in the population. However, very recently, World Bank (WB) and World Health Organization (WHO) undertook a joint exercise to quantify the impact in loss of life from about 100 diseases and injuries in. 1990. The GLOBAL BURDEN OF DISEASE (GBD) combined the loss of life from premature death in 1990, with loss of healthy life from disability.

The GBD is measured in units, of DISABRILITY ADJUSTED LIFE YEARS (DALYs).

Though there are shortcomings in the calculations of DALYs, under the existing conditions of knowledge of diseases and their impact on health, DALY's make a valuable contribution to understanding of comparative health situation. (World Bank, 1993)

Also important was the fact that the ratio of loss of DALYs male/female was 0.92 for India and 1.30 for EMEs (countries of established market economies) indicating that, seen as an overall situation the Indian women are not only at a disadvantage compared to the men, but, the gap is far wider than what one would normally expect. However, this was not true for all ages. In India M/F ratio is unfavorable to females till age 44. For the survivors beyond age 44 the situation was different. After age 44, it is unfavorable to males. In EMEs it is unfavorable to males throughout the age-span.

The World Bank report further points out, that, of the 292.5 million DALYs lost in India, 200.6 million (68.6 per cent) (100.8 million by males and 99.7 by females) mere lost due to death and 91.9 million (31.4 per cent) (44.5 million by males and 47.4 million by females) due to disability. Of the 93.6 million DALYs lost in EMEs 49.2 million (52.6 per cent) (29.5 million by males and 19.6 million by females) were lost due to death and 44.4 million (47.4 per cent) (22.5 million by males and 22.0 million by females) due to disability. EMEs therefore show that there were higher chances of survival even when disability could not be avoided.

Ratio of deaths to disability in EMEs for males was 1:1.3 and for females it was 1:0.9. In India ratio of deaths due to disability for males is 2:3:1 whereas for females it is 2:2:1.

The above ratios show that the chances of dying, instead of facing disability, are high for both the males as well as the females in India and for the males in EMES. Whereas, for females in EMES, chances of survival have an edge over the chances of facing a life with disability.

It is important to note, that, in India, contribution to DALYs lost due to deaths is slightly higher for the males than for the females. Same pattern was observed for the populations in the EMES, however the advantage to females in EMEs was larger. Larger numbers of females suffered disability in India, whereas in EMES, it is the males who suffered a greater loss due to disability.

In India of the 200.6 million DALYs lost due to deaths, 108.1 million DALYs (53.9 per cent) (53.0 million for males and 55.1 million for females) were contributed

by children under age 5. The next age group of children, aged 5 to 14, contributed 20.2 million DALYs (10.1 per cent) (9.4 million by males and 10.8 million by females). Thus, in India, of the total DALYs lost due to deaths 64 per cent were contributed by children under age 15. By contrast, in the EMES, of the total 49.2 million DALYs lost due to deaths, 3.5 million DALYs (2.0 million by males and 1.5 million by females) were lost due to the deaths of children under age 5 and 0.8 million DALYs (0.5 Million by males and 0.3 million by females) due to deaths of children in ages 5 to 14. In other words 4.3 million DALYs (2.5 million by males and 1.8 million by females) were contributed by the deaths in childhood. Thus loss due to deaths in childhood, under age 15, contributes only 8.7 per cent to the total DALYs lost due to deaths in EMES.

Of the total 91.9 million DALYs lost due to disability in India the contribution of children under age 5 to the loss was 29.1 million DALYs (31.7 per cent) (14.2 million by males. and 14.9 million by females) and of children in ages 5 to 141 was 12.1 Million DALYs (13.2 per cent) (6.4 million by males and 5.7 million by females). Thus, children under age 15 contribute 44.9 per cent of the total DALYs lost due to disability. In the EMES, of the 44.4 million DALYs lost due to disability 2.9 million (6.5 per cent) (1.5 million by males and 1.4 million by females) were contributed by children under age 5 and 1.4 million DALYs (3.2 per cent) (0.8 million by males and 0.6 million by females) by children in ages 5 to 14. In HIEs, therefore, the contribution of children under age 15 to total DALYs lost due to disability was 9.7 per cent.

Above discussion on the contribution due to deaths and due to disability should explain the quality of life of the population in India, in comparison to that enjoyed by the population in EMES. It should be noted that this discussion presents only the. partial picture, because, it does not live, with the major contribution of the society and the available technology. It also does not consider the disabilities suffered due to malnutrition, poor growth and stunting, which affect the performance in productivity and general living.

Since women are biologically 'stronger' it is observed that, the risk to the life of women at ages above 35 is far less and in ages 35 to 49, the risk to the life of a woman is lesser by 28 per cent in comparison to that for a man. At ages above 50, the risk to the life of a woman is lesser by 14 per cent. (Calculated from the age specific death rates, SRS)

Poverty, Nutrition and Women's Health

It is now accepted that there is a direct relation between level of nutrition and work performance of the mother on the one hand and incidence of low-birth weight children on the other. Such children not only experience higher risks to

their survival, but they experience poor growth and development. Consequently, they contribute in larger numbers to school dropouts, as well as, poor labor force. Thus, malnourished mothers perpetuate the cycle of poor quality populations, and the policy that neglects nutrition of people, especially of women, are perpetuating the cycle of poor quality of population. It is widely acknowledged that, the dietary intake of nutrients of a majority of rural Indians and underprivileged urban populations of both sexes are below the desirable level. The extent of deficiencies depends upon the age and socio-economic status. Body weights, of different age groups, particularly of those belonging to low, income groups are below reference body weights as a result of chronic malnutrition from birth to adulthood. It is the cumulative effect of under-nutrition, right from conception through infancy, childhood and adolescence. The body weights of rural and slum populations, which constitute majority of the total populations, are 70 to 85 per cent of reference body weights at different ages.

Nutritional status of large sections of Indian pregnant women belonging to the poor income groups, has changed little, judging from their dietary intake and anthropological measures. Prevalence of anemia too seems to have not been attended. In addition, impoverished women spend more time and energy producing food or looking for food that they can afford to buy. They work longer hours, if they have paid work "or stay longer in the market, to trade. Usually uneducated, they are obliged to accept whatever work they can find, often the most dangerous, backbreaking and least desirable. The consequences for their health and that of their families can be disastrous. At best they face a slow, inevitable decline in vitality, premature aging and earlier death.

Poorer women experience 20 per cent foetal wastage and perinatal 50 to 70 per 1000 live births. It has been observed that irrespective of economic status, most women do not meet the standards for height and weight. As a result, they face complications during pregnancy and delivery. Women with poor physical growth need medical help, during their deliveries. Many of them require to undergo caesarian deliveries. Since over 83 per cent of the rural and 42 per cent of the urban women are delivered by untrained attendents, they do not have access to the much needed medical help. (NFHS, 1993) It is thus observed that maternal mortality in India is one of the highest in the world, excepting that experienced in some of the African countries. Further, it is observed that for every woman who dies as many as 17 women suffer serious damage to their health because of maternity.

TFR (Total Fertility or the total children born to a woman has shown a decline from 5.8 in 1970 to 3.7 in rural areas and to 2.7 in urban areas by 1992-1993. However this change has been brought about by the births at higher ages. NFHS data show that, the age at first birth continues to be low. (15 years in Uttar

Pradesh and even in progressive States like Maharashtra and Karnataka it is between 17 and 18 years.) Of the total births over 50 percent are to mothers below the age of 19 years.

Indian populations experience high infant, child and maternal mortality. Promoters of population control programs suggest family planning as a solution to these problems. However, reducing births through practice of contraception is likely to reduce the number of deaths among infants, children and mothers, but will not reduce the risk to the lives of these individuals, because, the cause of risk is their poor health and this is rooted in the economic as well as socio-cultural situation that they face throughout their lives. Besides poverty that denies resources, the discrimination against women aggravates the problems.

Among the solutions to the current problems is the need to fight patriarchy-the power relationship that prevails in society by which men dominate women. Women's subordination in areas such as discrimination, disregard, insult, oppression, violence within the family, at work and in society, must be immediately attended to. Wife battering, male control over women and girls, sexual harassment at work, lack of educational opportunities for girls, lack of inheritance or property rights for women, male control over women's bodies and sexuality and lack of control over fertility, are some of the issues that are related to the status of women and consequently, the status of the population in general. Promotion of population control through control of female fertility will not only not improve quality of life, but such programs that are essentially patriarchal will help in further subordination of women.

Currently main institutions in the society--the family, religion, media, law, are the pillars of the patriarchal system. Over generations these institutions have destroyed women's self-respect, self-esteem and confidence and have set limits to their aspirations. The struggle for women's emancipation is a struggle for the achievement of women's equality, dignity and freedom of choice to control for living and control over their bodies within and outside the home. Health movement can become an important. entry point, for the emancipation of women by improving the social and cultural conditions that are the root causes of their present poor health. Economic policies for improving the economic conditions of the people are not only essential, but, unless care is taken to see the benefits of the policies reach all sections of the society as well as the men and the women, the gains which work in the directions of strengthening the current social norms and those that come in the way of the progress of the deprived and of the women. No society can progress by promoting the interests of only sections of its populations.

At the root of the population problem-both qualitative as well as quantitative is the status of women in the population. It will also be seen that improving the health of women will require not only looking at the health conditions, generally discussed by the health professionals, but, will involve in large part, re-examining sexuality with social and cultural mores and therefore, hierarchical and patriarchal nature of the society. It will entail improving male, as well as adolescent sexual health and more importantly, involving men in the health programs. In short, securing women's health will mean a social transformation.

Body weights of women of different age-groups, as a result of chronic under-nutrition low-income groups are below reference body weights from birth to adulthood. It is the cumulative effect of under-nutrition right from conception through infancy, childhood and adolescence. The body weights of rural and slum populations, which constitute a majority, are 70 percent to 85 percent of reference body weights at different ages. (Women and Nutrition in India, 1990).

The world's poorest women are not merely poor. They live on the edge of subsistence. They are economically dependent and vulnerable, politically and legally powerless. As wives and mothers, they are caught in a life cycle that begins with early marriage and too often ends with death in childbirth. They work longer hours and sometimes work harder than men, but their work is typically unpaid and undervalued.

What is more depressing, is the fact that, over the years, economic disparities in all the countries of the world have rapidly widened, condition of the poor worsened and the injustices against women, aggravated, it is, also true that the policies that are adopted at the international and the national level are designed to widen the gap rather than narrow it.

Consumerism, Environment and Women's Health

Describing the wide disparities in distribution of resources, During writes, "Since 1900, the value of goods and services produced each year world-wide has grown twenty-fold, the use of energy thirty-fold, the products of industry fifty-fold and the average distance travelled by the well-to-do, perhaps, thousand-fold. As the century enters its final decade, commoners of the world's affluent nations live like royalty of yesteryear, and elite's literally live like gods---crossing continents on the winds and bending the forces of nature to their will."

Durning further adds, "and yet the disparities in the living standards that seperate the poor from the rich are nearly beyond comprehension. The world has 157 billionaires, and perhaps 2 million millionaires, but 100 million people around the world are homeless, living in sidewalks, in garbage dumps, and

under the bridges. Americans spend $5 billion each year on special diets to lower their calorie consumption, while the world's poorest 400 million people are so undernourished that they are likely to suffer stunted growth, mental retardation, or death. As water from a single spring in France is bottled and shipped to the prosperous around the world, 1.9 million people drink and bathe in water contaminated with deadly parasites and pathogens, and more than half the humanity lacks sanitory toilets."

It is now well accepted that over 75 per cent of the poor, anywhere in the world, are women and children. The victims of the above mentioned disparities are, therefore, largely women and children. It is to be noted that conditions of women and children not only influence the present but they overwhelmingly determine the future. It is well known that higher incidence of low-birth-weight babies observed in most of the developing countries is the result of neglect of women from their childhood and their poor health.

These children contribute to the poor of the future who experience high morbidity and mortality. High infant and child mortality in these countries results in high fertility of the mothers, who have to produce larger numbers of children to assure survival of at least some. Also, since the women receive poor returns for their labor, their children are required to join as child labor, depriving them opportunities of physical growth and development and adding to the ranks of illiterates in the community. Vicious circle of poverty, leading to lack of opportunity for improving the future, condemns women and children to lives of misery.

Population control programs talk of environmental degradation and poverty. Women are rarely causes of environmental degradation, but they certainly are their victims. Shortages of water, fuel and fodder are known to increase women's workload. Also the harmful effects of pollution and degraded lands affect health of women and the family members. Being protectors of health of the family as well as being health workers, women face additional burdens of these problems.

It is accepted that growth of population in the higher growth rate countries needs to be controlled, especially since the high fertility of women is endangering their health as well as their well being. But more important is the control of consumerist life-style of the industrialized countries and the rich in the Third World countries. 20 per cent of the populations of the world living in the industrialized countries are consuming over 80 per cent of the world resources. Their consumption of the resources is affecting environment, much more than the growing population of the poor countries. They are consuming resources of the Third World countries, whereas the populations of these poor countries are blamed for environmental degradation. It is now accepted that degradation of

the environment is 100 times more by the US than by entire population of Bangladesh, which is one of the countries with higher population growth rate and is a major target of the population control programs.

It is also clear that poverty cannot be abolished by the capitalist system since it is actually produced and perpetuated by the very logic of its functioning. It is the very policies of the existing system that marginalize women. It is for this reason that DAWN's (Development Alternatives for Women) New Era says: "While traditional gender based systems of subordination have been considerably transformed by the forces of economic growth, commercialization, and market expansion, subordination itself persists, although in some cases more impersonal forces in the labor market replace the direct control of women within the patriarchal rural households. We must understand the impact of these processes on women's relative access to resources, income and employment, as well as sexual division of labor. The almost uniform conclusion of the research is that, with a few exceptions, women's relative access to economic resources, incomes and employment has worsened, their burdens of work have increased, and their relative and even absolute health, nutritional and educational status has declined."

References

1. Baneiji D. (1983) National Health Policy and Its Implementation, Economic and Political Weekly, January 22, pp. 105-109

2. Census of India (1991) Sefies-1, Paper-1 of 1991, Provisional Population Totals, Registrar General and Census Commissioner of India, New Delhi, p. 71

3. Datds ffingsley and Pietronella van der Over (1981) Age Relatiorr and Public Policy in industrial Societies, Population and Development Review, Volume 7, Number 1, March, pp. 1-1 8

4. Dutta K. K. (1980) Mortahty Pattems Amongst Rural Pregnant Women in Alwar, Rajasthan-A cohort study, Health, Population Perspective Issues, Volume 3.

5. Karkal Makni (1985) Health of Mother and Child Survival, in "Dynamics of Population and Family Welfare" 1985, eds. K. Sidnivasan and 5. Mukeili, Himalaya Publishing House, Bombay, PP.358- 374
6. Karkal Mahni (1 986) Planning for Female Feticide, Science Age, September, pp. 13-15

7. Karkal Malini (1 987) Differentials in Mortality by Sex, Economic and Political Weekly, August 8, pp1343-1347

8. Karkal Mahni (1 990) Invisibility of Girl Child in India, The Indian Journal of Social Work. Volume LJI, Number 1, January

9. Karkal Malini (1991 a) Health and Health Services in India, in Primary Health Care ed. C. A. K Yesudian, Tata Institute of Social Sciences, pp. 12-32

10. Karkal Makni (1991 b) The Demographic Patterns of Women's Development, Paper presented at the Fifth National Conference of the Indian Association for Women's Studies, Calcutta, February 9-12

11. Karkal Malini (1992) Kerala's Success Goes Beyond Family Planning, Independent July 8

12. Karkal Malini and Rajan S. Irudaya (1989) Age at Marriage: How much Change? Economic and Political Weekly, March 11, pp. 505-50 7

13. Karkal Malini and Rajan S. Irudaya (1991) Proidson of Basic Human Needs in India, 1961-1981, Economic and Political Weekly, February 23, pp.443-451

14. National Family Health Survey (1 993) International Institute for Population Sciences, Bombay

15. Nutrition Foundation of India Bulletin (1991)

16. Nutrition Reviews (1948)

17. Royston Erica and Armstrong Sue (1989) preventing unwanted Maternal Deaths, Geneva

18. Ruzicka Lado T. and Hansluwka Herald (1982) Mortality Transition in South and East Asia, Technology Confronts Poverty, Population and Development Review Volume 8, Number 3, September, pp.567-588

19. Sen Amartya (1994) Population: Delusion and Reality, The New York Review, September 22, p. 63. Women and Nutrition in India eds. C. Copalan and Surinder Kaur, Nutrition Foundation of India, Special publication series 5, p. 94

20. World Bank (1993) World Development Report 1993, Investing in Health, World Development. Indicators, Oxford University Press