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OUR COVER

The UN Decade for Women, launched in 1976, was a bid to attract worldwide attention to the inferior status unfairly conferred on one half of humanity, and to spotlight the huge contribution—all too grudgingly recognised—that women make towards development. What has the Decade achieved? This issue of *Swasth Hind* is dedicated to the women's welfare.

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THE STATE OF THE WORLD'S WOMEN 1985

A DECADE FOR WOMEN

THIRTY years after the United Nations first announced its commitment to equality between men and women in its Charter of 1945, concern over the continuing unequal status of women led to the declaration of 1975 as International Women's Year. For the first time in history the eyes of the world were focused on that half of its population who, by virtue of an accident of birth, perform two-thirds of the world's work, receive one tenth of its income and own less than one hundredth of its property. It was the start of an international effort to right the wrongs of history. That same year the United Nations General Assembly declared the years between 1976 and 1985 to be the United Nations Decade for Women.

Marking the end of that decade, is the World Conference on Women held in Nairobi in July 1985, where delegates from over 140 countries assessed the achievements of ten years of international commitment to improving the status of women.

Both individual governments and United Nations' agencies have played their part in a research effort of unprecedented scope, the fruits of which were presented to the Conference. Over the last year the United Nations has been compiling the results of a questionnaire completed by 121 governments reviewing and appraising the position of women in their countries. At the same time United Nations' agencies have themselves been amassing a fund of independent research from all over the world to complete the picture.

The findings reveal: that women do almost all the world's domestic work which, together with their additional work outside the home, means most women work a double day; that women grow around half of the world's food, but own hardly any land, find

it difficult to get loans and are overlooked by agricultural advisors and projects; that women are one third of the world's official labour force, but are concentrated in the lowest-paid occupations and are more vulnerable to unemployment than men; that, although there are some signs that the wage gap is closing slightly, women still earn less than three quarters of the wage of men doing similar work; that women provide more health care than all the health services put together and have been major beneficiaries of a new global shift in priorities towards prevention of disease and promotion of good health; that the average number of children women want has dropped from six to four in just one generation; that women continue to outnumber men among the world's illiterates by around three to two, but that a school enrolment boom is closing the education gap between girls and boys; that 90 per cent of countries now have organizations promoting the advancement of women; but that women, because of their poorer education, their lack of confidence, their greater workload, are still dramatically under-represented in the decision-making bodies of their countries.

The results point, again and again, to the major underlying cause of women's inequality. A woman's domestic role as wife and mother—which is vital to the well-being of the whole of society, which consumes around half of her time and her energy—is unpaid and undervalued.

A picture has emerged over the Decade of the importance and magnitude of the multiple roles women play in society. This has been reflected in a growing climate of concern for women among governments and the community at large, and is responsible for the positive achievements of the Decade: better health care and more educational and employment opportunities.

The inter-related themes of the Decade—equality, development and peace—reflect the complexity of the changes needed before women can take their rightful place in the world beside men.

Equality does not just mean achieving legal equality for women and eliminating discrimination. It means women having equal rights, responsibilities and opportunities in every aspect of life. And this can only happen if women have the means, and the power, on the same basis as men, to allow them to take an equal role.

Development means growth and improvement for women in every field of human life: economic, social, political, cultural. And it must be part of the worldwide movement to establish a more equitable sharing of the world's resources between countries and people.

Without peace and stability there can be no development. And peace will not be lasting without equality, without eliminating inequalities at all levels, between men and women, between the haves and the have-nots within countries, and between nations themselves. ○

WOMEN'S HEALTH

Primary health care

THE Decade for Women saw the launching of what the World Health Organisation (WHO) calls "the most optimistic statement of purpose ever made by the world community". In September 1978, 134 nations met at Alma Ata in the USSR and pledged their support for a world-wide effort to bring "health for all by the year 2000". Primary health care was to be the key to the success of this effort.

The principles were simple enough. If 80 per cent of all illness in the world is caused by the lack of clean drinking water and sanitation, then improving water and sanitation would have to become a priority. With malnutrition affecting one in four people and making them more vulnerable to disease, basic nutrition would also have to be part of the package. On the medical front, a simple vaccination could prevent some of the commonest infectious diseases. And, where drugs were not enough, an army of primary health care workers—trained in the principles of prevention as well as cure—could help motivate people to change their habits and make their communities safer places to live.

Primary health care played a spotlight on the causes of disease and it picked out women—standing, centre-stage—bearing the brunt of responsibility for their families' health. Suddenly the eyes of health planners began to turn towards women: as cooks and feeders of children: as fetchers of water and firewood; as custodians of cleanliness and hygiene; as teachers of healthy habits.

"Women are the vast untapped resources for development", declared WHO in 1980. "The anchor of our strategies for health development should relate to all-round improvement in the status of women and children who form the majority of any population."

Nutrition

The United Nations' Children's Fund (UNICEF) estimates that 200 million under-fives are malnourished and that 10 million of these are so severely thin that they risk death. Figures like these demonstrate the potential of helping women feed their children better.

Fifty countries have now begun nutrition programmes and 25 of these have developed them especially for women. In the Virgin Islands pregnant women and malnourished children are provided with margarine, wheat-flour and dried milk powder to supplement their diets. And the importance of extra food like this has been demonstrated in Guatemala where one project giving supplementary food to pregnant women reduced the incidence of low birth weight among babies by 75 per cent.

Water and sanitation

The Decade for Women also saw the launch of another major worldwide initiative: the International Drinking Water Supply and Sanitation Decade which began in November 1980. WHO estimates that (excluding China) 25 per cent of people in cities and 71 per cent of those in the countryside of developing countries are without safe water to drink and 47 per cent of town dwellers and 87 per cent of people in rural areas have no adequate sanitation.

THE WORLD OF MOTHERS

Most mothers in the developing world are already doing the best they can for their children within the resources of time, energy, income and knowledge available to them. Increasing those resources is a prerequisite of drastically improved health for children — and for mothers themselves. (UNICEF)

MALNUTRITION



AVERAGE WEIGHTS OF WOMEN IN:

USA 58 Kg

CENTRAL AMERICA 50 Kg

INDIA 45 Kg

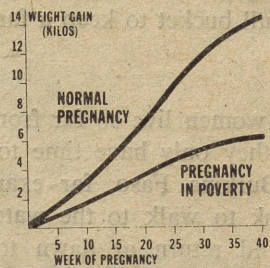
Most girls and women in the developing world do not get enough to eat. If properly fed, there is no difference in average growth between peoples of different continents.

ANAEMIA



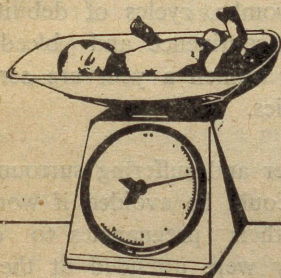
In the developing world, half of all women aged 15 to 49 are suffering from anaemia. Among pregnant women, the percentage is very much higher.

PREGNANCY



Because so many women have too little food and too much work, they often fail to gain sufficient weight during pregnancy. The result is the physical depletion of the mother and a greater risk of low birth-weight.

LOW BIRTH-WEIGHTS



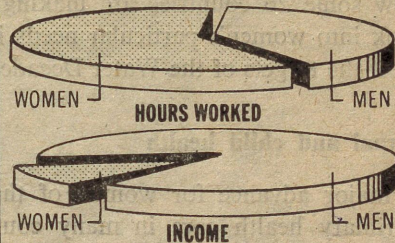
Maternal malnutrition can lead to low birth-weights — which are associated with a 30% greater risk of infant death.

MANY CHILDREN



Too many pregnancies too close together undermine the health of both mother and child. Child deaths are typically twice as high when the average interval between births is less than two years.

WORK



Women usually work longer in the fields than men and produce half of the developing world's food. With their domestic work on top, women work twice as many hours as men — for only one-tenth of the income.



Belinda Magee and Duncan Mil, The Observer, London Photograph: Werner Gartung

The consequences of being without these basic amenities are ill health for all and great hardship for women who often have to walk long distances to fetch water. A person needs around five litres of water a day for cooking and drinking, and a further 25 to 45 litres to stay clean and healthy. But the most a woman can carry in comfort is 15 litres. Even if she lives near a standpipe, that means about 15 journeys a day with a full bucket to keep a family of five in good health.

But some women live so far from the nearest water source that they only have time to make one journey a day. In Burkina Faso, for example, some women leave at dusk to walk to the water hole, sleep there overnight, and return at dawn to escape the harsh rays of the sun. Small wonder that an estimated eight million children die each year of diseases that might have been prevented by sufficient clean water from a nearby tap.

Now some 26 countries are making a special effort to look into women's particular needs in their attempts to meet the targets of the Water Decade.

Maternal and child health

A major advance for women of the new emphasis on primary health care in many countries is the increasing attention paid to providing better care for pregnant mothers and their babies. Maternal and child health—or MCH, as this aspect of primary health care is called—involves prenatal check-ups, immunization and advice on child-care, breastfeeding and weaning foods. Forty-two governments reported that they have expanded their MCH activities during the Decade, with Senegal actually restructuring its entire Ministry of Health to incorporate this new commitment.

Proponents of MCH in the US have estimated that \$2.7 million spent on prenatal services would save between ten and 12 million dollars currently spent keeping premature, low birth weight babies alive in intensive care units. And when prenatal consultations in Portugal rose eightfold—from 19,000 in 1975 to 150,000 in 1982—maternal and infant mortality rates plummeted by 12.9 and 12 per 1,000 respectively.

There has also been more attention paid to screening whole populations of women to pick up diseases in their early stages. Nine countries have introduced such screening procedures. The USSR, for example, has established a twice-yearly medical check-up for women

at their workplace. And in China deaths from cervical cancer dropped from 111 to eight per 10,000 following the introduction of screening.

Birth and death

All over the world women in labour are usually tended by women. Some rely on traditional methods, passed down through the generations from mother to daughter. Others reach into new midwives' kits given to them after a short training course. Others are the product of years of training in the long corridors and modern delivery rooms of a teaching hospital.

The majority of women deliver safely. But many die in childbirth: over half a million every year in Africa and Asia, three out of every thousand mothers in Ecuador and up to 20 out of every thousand in Honduras.

Though thousands die many millions survive and have to live on with the scars of a difficult pregnancy: displaced or weak wombs, cycles of debilitating infection, exhaustion, incontinence and bleeding. An estimated 25 million women a year are seriously ill after having their babies.

Much of the danger and suffering surrounding and following childbirth could be avoided if women were examined early in their pregnancies to check for abnormalities, if they were attended at the time of the birth by trained midwives or doctors, if there were emergency health care at hand should something go wrong, and if family planning facilities were available to all women who want them. But the World Health Organization estimates that 45 per cent of births are delivered by untrained traditional birth attendants, and that two-thirds of women in the developing world have no access to a trained health worker.

The dangers are made worse by the weak state many women's bodies are in by the time they feel the first pains of labour: thin from lack of food, exhausted from work and the demands of previous pregnancies. The result: two thirds of women in Asia, half of African women and a sixth of women in Latin America are anaemic.

These women are suffering from "nutritional anaemia": caused simply by lack of the right kind of food. In India though rich women eat around 2,500 calories a day and put on an average of 12.5 kilograms of weight during their pregnancies, poor women eat around 1,400 calories a day and gain only 1.5

kilograms during those crucial nine months. One African study found rural women in their last three months of pregnancy actually lost weight—an average of 1.4 kilograms each. Little wonder, then, that such women bear tiny, underweight babies. One sixth of all babies—95 per cent of them in the developing world—weigh under 2,500 grams when they are born.

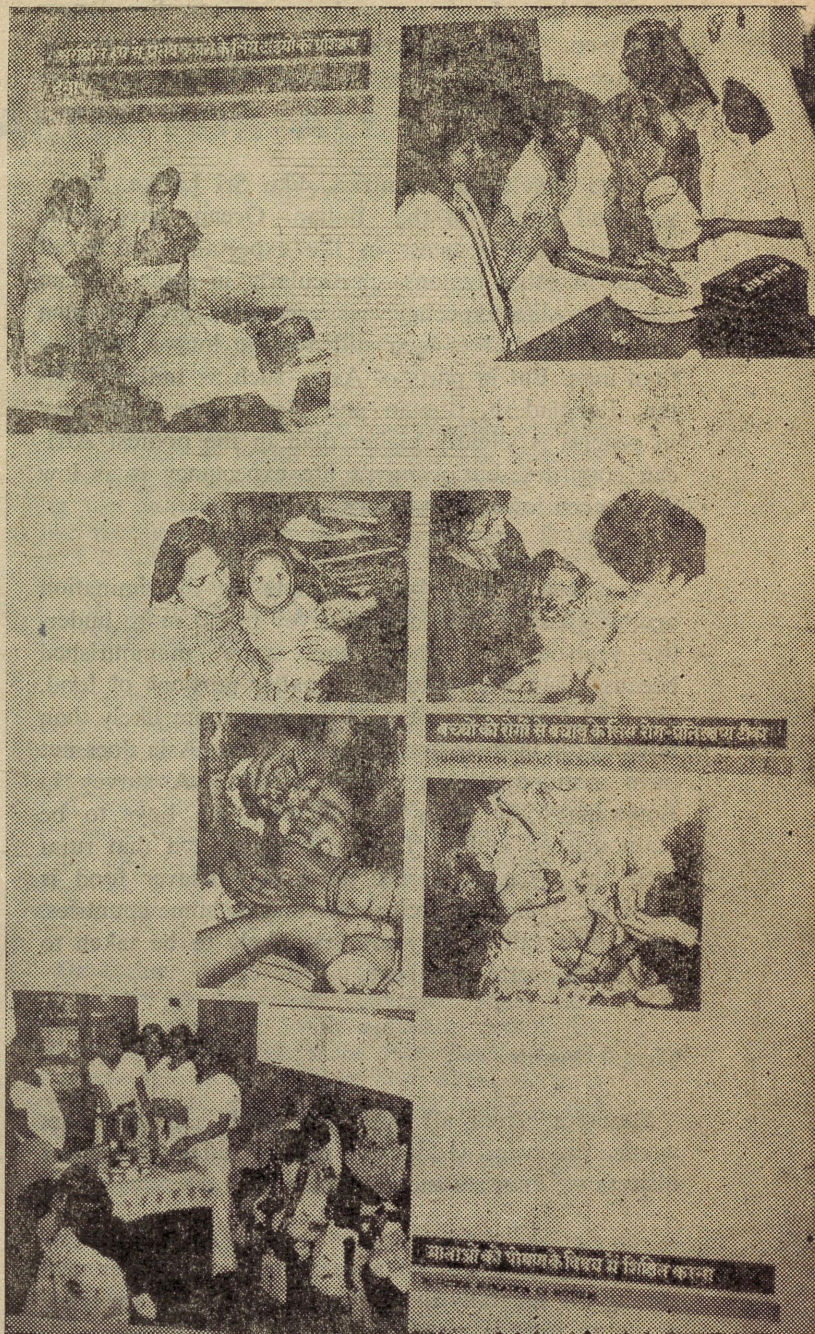
The illnesses of the general population affect women too. At least one person in three harbours some species of parasitic worm; one in 20 has bilharzia; and malaria—once thought to be on the decline—has made a massive comeback to grip one person in six in its fevers. Taken together infectious and parasitic diseases cause around 40 per cent of deaths in the developing world.

Sickness in any country is bad enough. But in the developing world—where many families' livelihood is precariously supported only by constant hard work—a sudden acute bout of illness or a strength-sapping chronic disease can be disastrous. People with anaemia in Indonesia, for example, have been found to be 20 per cent less productive than healthy adults and bilharzia's annual impact on the income of its victims has been estimated to total around \$ 650 million.

But not all sickness has a medical cause. Accidents at work kill 100,000 and maim millions annually; and at least 10,000 die and 500,000 are seriously poisoned every year by careless use of pesticides. Some work hazards are likely to affect women more than men. Byssinosis, for instance, is an incurable lung disease caused by inhaling cotton fibres and thought to afflict one quarter of India's textile workers, who are predominantly women. Pesticide poisonings may affect women more since their agricultural work tends to bring them into closer contact with the crop. And in the electronics factories of South-east Asia 25 year-old workers are called "grannies" by their younger colleagues because they have to wear glasses after damaging their eyes peering through microscopes for hour after hour assembling tiny silicon circuits.

Vulnerability of women

There is now more information available on the health of women than ever before and some interesting findings are beginning to emerge. Take lung cancer. WHO estimates that smoking causes around one million deaths a year and tobacco consumption increased at a rate of between four and 13 per cent in the industrialized world and 33 per cent in the developing world between 1970 and 1980. Once a habit indulged in largely by men, the recent increase in women



Maternal and child health care involves prenatal check-ups; safe delivery; immunization; advice on child-care and breastfeeding and education on better nutrition.

smoking is now threatening, says WHO, to "chip away at increased life expectancy for women". And a growing body of research shows that babies in the womb can also be harmed by the cigarette smoke inhaled by their mothers.

Life expectancy varies considerably from country to country, but almost everywhere women live longer than men. In the industrialized world women live—on average—six years longer. In developing countries the gap is narrower.

Some developing countries—like Sri Lanka, Malaysia and islands in the Indian Ocean—have made dramatic improvements in life expectancy in recent years. In other regions—particularly in some African countries—life expectancy is very low for both men and women, but women still average longer lifespans than men. But in parts of Asia—such as India, Pakistan, Bangladesh, Bhutan and Nepal—life expectancy in general is slightly higher than in the poorest African countries, but *women's* life expectancy is as low as, or even lower than, men's.

The reason may be as simple as discrimination against girls. A Bangladesh survey found more under-five year-old girls than boys were malnourished because they were allocated smaller portions of food, and that infant girls were 21 per cent more likely than boys to die in their first year of life. But Asia does not have a monopoly on discrimination. A survey in Botswana found girls more likely than boys to be malnourished and in Turkey it is reported that rural men are given the lion's share of whatever food is available. Other research shows that, in some countries, when girls fall ill they are less likely to be taken to the health centre than boys.

Mental health

Statistics from all over the world indicate that women are twice as likely as men to suffer the kind of distress we know as mental illness.

In Bangladesh, for instance, women outnumber men among the mentally ill by two to one. There are twice as many women as men diagnosed schizophrenic in Sweden. In the UK 11 per cent of men and 17 per cent of women are hospitalized at some time in their lives for mental illness and twice as many women as men take tranquillizing drugs.

Whether these figures are a real reflection of human psychological suffering or a result of a greater tendency for psychiatrists and doctors—usually men—to diagnose a distressed woman as being mentally ill is unclear. But, whichever way these statistics are

interpreted, they reveal a particularly heavy burden of mental anguish carried by women.

Women as health workers

It is not only as recipients of health care that women have benefitted in recent years. As providers, too, their traditional contribution is at last beginning to be recognized. In the majority of societies with no regular access to modern medical facilities, it is often women who tend to emerge as the village healer or midwife—the *dai* in India, the *hilot* in the Philippines. Sierra Leone's 13,600 traditional midwives, for example, deliver 70 per cent of births, and 80 per cent of births in Honduras are delivered by such women.

In the past these women have found themselves in opposition to, and excluded from, modern medical advances. With the advent of primary health care such women's skills began, at last, to be appreciated. Now, instead of being fought or ignored, they are being trained all over the world in the principles of primary health care. India had trained a quarter of a million *dais* by 1981. Nicaragua has been training them at a rate of 900 a year. By 1978 Ethiopia had trained 45 per cent of traditional midwives; in Ghana and Sri Lanka the totals were 25 and 95 per cent respectively by 1976.

Costing less than two per cent of the money it takes to train a doctor, the logic of training women as health workers is clear. The benefits are clear too. In India, for instance, deaths from neonatal tetanus were reduced from 90 to 10 per 100,000 in the three years following the launch of the *dai* training programme there.

Resistance from doctors

But here women's involvement stops. In the higher ranks of the health services—among the doctors, the health ministry officials, the hospital administrators—where the high pay and the power reside, women are grossly underrepresented. Yet this is where the policy decisions get taken, where the money is distributed from. And that money tends to stay just where it is. Three quarters of the world's health problems could be solved by primary health care. But three quarters of developing countries' health budgets are spent on doctors and hospitals.

— UNICEF

Swasth Hind

WOMEN AND HEALTH FOR ALL

DR H. MAHLER

THE situation of women—who make up half of the World's population, perform two-thirds of the world's work and receive one tenth of its income, was the subject of discussion at the World Conference to Review and Appraise the Achievements of the UN Decade for Women held from 15 to 26 July, 1985, at Nairobi.

The Conference had a dual purpose : to take stock of a 10 year effort on the part of the United Nations and its member states to improve the status of women; and to advise strategies for women's further advancement during the remainder of this century.

This is the third time the United Nations has convened an international conference on the status of women. The Decade for Women (1976-85) was proclaimed by the General Assembly on the recommendation of the World Conference of the International Women's Year, held in Mexico City in 1975. The World Conference on the Decade was held mid-way through the Decade (1980) in Copenhagen.

Women need to be considered for their own worth, as equal members of society, rather than only as mothers, potential mothers or carers, according to Dr Halfdan Mahler, Director-General of the World Health Organization (WHO).

Addressing the World Conference to review and appraise the achievements of the UN Decade for Women 16 July, 1985 Dr Mahler went on: "They need to be seen beyond the limits of their contribution to family life, and they want to start sharing the responsibility for others with the men in their lives and the men in their societies as a whole."

The Director-General said that WHO's goal of Health for All by the Year 2000 aims at all people whatever their present level of social and economic development, but social justice demands that greatest attention be paid to the underprivileged, so that they become able to extricate themselves from the poverty equilibrium in which they are trapped. But they should avoid falling into another trap—that of excessive medical consumption as part of a consumer society. "Health for all is thus

a moving target," he went on. "As a certain health status is reached, people will try to reach a higher level, and so on."

He distinguished between two possible scenarios for the future of health and society. The male one is the Hyper-Expansionist ("HE") scenario standing for unconstrained technological development. The female scenario is the Sane, Humane, Ecological ("SHE") one, standing for the caring, nurturing role in societies. He commented: "Health for All by the Year 2000 is squarely belonging to the 'SHE' scenario".

Development in terms of the "HE" scenario had far from always been beneficial for women, and especially so in developing countries. "We know that girls get less food in some developing societies than boys do—so how can they grow properly? We know that girls receive no schooling—so how could they make their own living as women? We know that images created by men of women shape women's lives."

Dr Mahler went on: "Families headed by women are on the steady increase, while these women do not have viable economic options for self-support and development. The female unemployment rate is on the rise everywhere. Experts speak indeed of the feminization of poverty, and even in countries where—by legislation, constitution and ideology—women are proclaimed equal, one does not see them where the power is."

He told the delegates: "Perhaps when you go back to your countries and you read the great love poems of your culture written by men about women, or you make health care policy decisions as men about women—for example about pregnancy and delivery (an issue which stands at the cross roads between the technological imperative and caring in health delivery systems)—perhaps..... it might lead you to think about a 'SHE' scenario in health—about a more caring society that gives, not only to men but also to women, both bread and roses, poetry and power. It is that scenario which will bring about 'health as if women truly mattered,' and which in turn will bring Health for All by the Year 2000 from a social dream to a social reality."



THE DEVELOPMENT OF INDIAN WOMEN

SMT. SERLA GREWAL

During the International Women's Decade, problems of women in India received focussed attention. Women's welfare is now an integral part of the planning process in the country and for the first time in our country's planning history, a chapter on "Women and Development" was included in the Sixth Five Year Plan document, says the author in this paper, which was presented at the Regional Conference on women, Population and Development, held at Beijing, Peoples Republic of China, from 25-30 April, 1985.

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IN the ancient times, women in India enjoyed a very high social status. In our Holy scriptures, there is a saying which, translated into English, reads something like this; "The land in which women are worshipped is the abode of Gods". With passing times the status of women in the society was gradually lowered. During mediaeval ages, their status was reduced, more or less, to that of a slave. This situation continued for hundreds of years although there are some exceptions where certain women ascended to high power and glory.

In the last 100 years, the picture has changed radically. Some of our leading social reformers like Swami Vivekananda, Raja Ram Mohan Roy and Mahatma Gandhi fought relentlessly for the emancipation of women. Indian women played a major role in the freedom struggle against the British rule. They fought, sacrificed, organised and marched shoulder to shoulder with men. Mahatma Gandhi, the architect of India's freedom, had a strong belief in women power. He was able to channelise this vibrant energy in the cause of national liberation. At his call, thousands of women left their households and hearths and took to the streets along with the menfolk to join in the freedom movement.

Equal status for women

After attaining Independence, it was only natural that in the Constitution of India, which was adopted in 1950, women were given equal status to men in political, social, economic and all other

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spheres of life. The Preamble to the Constitution promises justice, liberty, equality and fraternity to all its citizens. It ensures equality before law and forbids discrimination against any citizen on the ground only of religion, race, caste, sex, place of birth. It also forbids discrimination in respect of employment under the State on grounds of sex. The Directive Principles of the State Policy which enshrine the spirit of the Constitution enjoin upon the State to ensure the right to adequate means of livelihood for men and women; to protect the health and strength of men, women and child workers from abuse and entry into jobs not suited to their strength; to ensure just and humane conditions of work and maternity relief for women.

Legal measures

Besides the Constitutional conferment of equality of status, various legal supportive measures have been instituted since Independence to protect and promote the interests of women. The Equal Remuneration Act (1976) provides for payment of equal wages for equal work to ensure that women are not discriminated against by paying them lower wages than the men. The Maternity Benefit Act (1961) provides 12 weeks' leave with full pay as maternity leave to women employees. The Factories Act (1948), the Labour Plantation Act (1951) and the Mines Act (1952) provide for welfare and protection of women working in these sectors of employment. The Factories Act also provides for creches to be maintained for children below 6 years in every factory employing more than 30 women. The Medical Termination of Pregnancy Act enables women to seek termination of pregnancies on medical, social, economic or psychological reasons without the consent of the husband. Apart from these laws to improve the economic status of women, a number of laws have been enacted to ensure social justice to women. Mention may be made here about a few of them. The Family Courts Act (1984) provides for setting up of family courts to decide cases relating to matrimonial problems, guardianship of children, adoption, etc. The Child

Marriage Restraint Act places restriction of marriage for females below the age of 18. The Special Marriage Act (1984) provides for compulsory registration of marriages and the Dowry Prohibition Act (1961) prohibits demanding benefits in cash or kind by the boy or his parents from the parents of the girl as a condition of marriage.

During the International Women's Decade, problems of women in India received focussed attention. Efforts were made to reassess the role of women in society, evolve suitable strategies for women's equality and development and to promote policies and programmes for their welfare. Measures were taken on all fronts, including legal reforms, education, health and political rights and today we have reached a situation where with justifiable pride, one can say that in India nothing, nothing whatsoever, except certain branches of the defence services, that is not open to a woman just because she is a woman. Women's welfare is now an integral part of the planning process in the country and for the first time in our country's planning history, a chapter on 'Women and Development' was included in the Sixth Five Year Plan document.

We fully subscribe to the view that welfare and well-being of the mothers should be our prime concern. In this context ability of women to control their own fertility forms an important basis for the enjoyment of other rights. We also subscribe to the view that the assurance of socio-economic opportunities on an equality basis with men and the provision of necessary services and facilities enable women to take greater responsibilities for their reproductive lives.

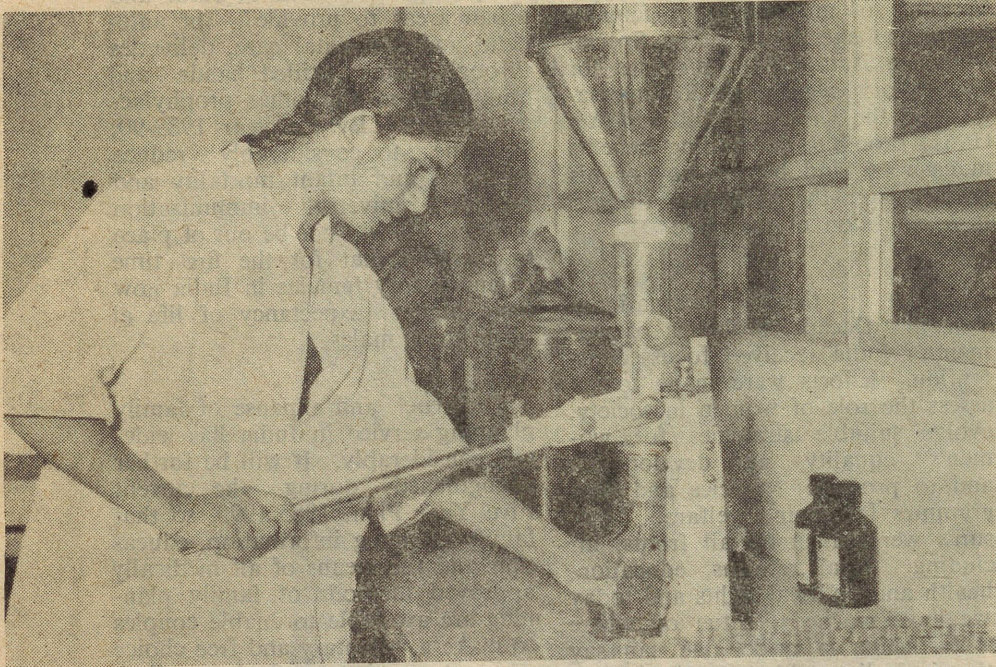
Programmes to promote the health of the women have been intensified; the maternal and child health care programme which is an integral part of our Family Welfare Programme has received a great boost. The infrastructure for delivery of maternal and child health services has been and is

being expanded both in rural and urban areas to provide for ante-natal and post-natal care, deliveries through better skilled hands and immunization and other prophylactic services. By the year 1989-90, we hope to considerably reduce maternal and infant mortality and provide universal immunization services. It will not be out of place to mention that for the first time in our history females in India now have higher expectancy of life at birth than males.

The reach and expanse of family planning service in India has widened considerably. It will be further strengthened during the current Five Year Plan, 1985-1990, so that family planning information, education and the means of all medically approved methods of family planning are available to enable couples to make a voluntary and free choice of contraception methods to limit their family size to desired levels. Family planning, however, is not the concern of women alone. We, therefore, promote active involvement of men in all areas of family responsibility including family planning and child rearing.

Formal and Non-Formal Education

Increased emphasis is being given on improving female literacy rate both through formal and non-formal education. During the decade 1971-81, female literacy rate improved from 18.7% to 24.8%. Realising the fact that literacy is going to be a major instrument for improvement in women's status, various programmes and schemes have been launched to provide education to the women. It is a matter of pride that for girls in India, education up to the high school has been made free. The 1981 Census revealed that out of 685 million persons, 331 million were women. The total number of women workers in the country is 63.52 million which means that for every 100 females the number of female workers is 14. Gainful employment of women has been identified as a major entry point in promoting women's integration with the development process. Between 1971 and 1981, the



Programmes are underway to promote women's access to science and technology for raising the status of women

overall work participation rate for women has registered an increase. The start of the International women's Decade in 1975 saw a National Plan of Action, drawn up by the Government which demanded strategies to be devised for increasing the participation of women in various occupations. Government has taken several steps to increase the employment opportunities for women in the organised and self-employment sectors. They are being given training for employment in various types of industries and upgradation of productive skills of women employed in traditional professions, both in organised and unorganised sectors. Various schemes have been framed for encouraging vocational training for women through a network of Industrial Training Institutes. Programmes have been taken up to promote women's access to science and technology and the age limit for

women scientists who want to take up research has been relaxed.

Although Government has provided an extensive legal framework to ensure women's right to equality, but laws alone do not change the traditional attitudes and prejudices. There has to be a popular upsurge and awareness to translate into reality the rights and aspirations of women.

In the field of population control, women in India are playing the decisive role. During our Sixth Five Year Plan, which ended in March this year, about 17 million sterilizations were done and about 7 million women took to IUDs. The number of women using Oral pills is multiplying very fast. More than 80 per cent of the sterilisation acceptors were women. It is only natural that since women feel the pinch of pregnancy that they should

be coming forward to accept family planning. The main point that needs to be highlighted in this connection is that women are coming forth to accept family planning in ever increasing numbers, sometimes even not caring for the fact that their men do not want it. When women can take initiative and succeed in this difficult area, there is no reason why they should not succeed in other areas.

From what I have said so far, it might appear as if everything is all right and there exists a situation of complete satisfaction. I do not wish to convey such an impression. It is, no doubt, true that we have travelled far and achieved a lot, but there is still far more to do and far ahead to go. Our efforts so far have tackled only a part of the problem. The legal provisions are there to protect women's interests, but there are also age-old inhibitions and prejudices in the society which militate against the enforcement of law.

Let us all keep in mind that our most important problem is to change the social attitudes that have prevailed for centuries. Let us also not forget that attitudes developed over such long periods do not change easily. It is precisely for this reason that the progress which we aimed at promoting has not been as fast as we would have wished it to be. What we are trying to strive for is really to telescope our achievements into a matter of decades which would otherwise require centuries to achieve. But, what we have achieved so far gives us the hope that the future is bright. ●

Courtesy: Centre Calling, August, 1985

WHAT WE DO FOR WOMEN

What India has been able to do for her women during the International Decade for Women?

“ARDHANAREESWARA” is a unique Indian concept. It roughly means the God who is half woman. Legends say that Shiva, the most terrible of the Hindu Trinity, the God of destruction and devastation fell so madly in love with his wife Parvathi that he gave half his body to her and the body that emerged was half woman and half man. Both lost their sexual identity in this new asexual god-form. The immortal Kalidasa describes the same pair as inseparable as the word and its meaning is one of his invocational stanzas. Interestingly, two of the Trinity are monogamous while the third thrives in a state of enforced celibacy. From this supreme state of equality, Manu, Draco's Indian counterpart declared that the females of the species do not deserve freedom since they are looked after by their fathers in their childhood, by their husbands in their youth and by their sons in their old age. In between Ardhanareeswara and “na stree swatantryam arhati” (women deserve no freedom) the pendulum of time took a full swing and women became relegated to the zenana as history corrupted society and eroded time honoured values in spite of all Gargis, Dinni Aarchas, Jhansi Ranis, Sarojini Naidus, Toru Dutts and Indira Gandhis.

Without much margin of error it may be said that the status of women in India was not significantly different from that of the women of England when Clive and Hastings laid the foundations of the white-man's empire in India and elsewhere. The British were here for quite some time. But, with their policy of social non-intervention, they did precious little to improve the lot of any deprived section of the Indian masses including women and children. Yet it would be tantamount to falsifying history to forget that it was the British who initiated legislation to put an end to some of the cruelties suffered by women such as *Sati* and child marriage. And to their credit it has to be said that they brought modern education and knowledge to those women who desired it.

After Independence

After independence, changes were rapid. Constitutional guarantee of equality was given to women by the founding fathers of our Republic. The far-reaching consequences and implications of such a step could seldom be grasped by the 'advanced' societies of the west, some of which are still to allow their women to vote. With reasonable pride we can say that in India today, nothing, nothing whatsoever, except certain branches of the Defence Services is denied to a woman, just because she is a woman.

The International Women's Decade added momentum to the progress achieved since independence. The committee on the Status of Women in India (CSWI), appointed in 1971 made comprehensive examination of all questions relating to the rights and status of women in the country.

It submitted its report “Towards Equality” to the Government at the beginning of the Decade. In fact, gender equality was never even considered by the CSWI as the principle was accepted some five decades earlier, through the fundamental rights resolution (1931) of the Indian National Congress. Instead, the Committee concentrated on how legal reform, education and political rights failed to benefit the majority of women afflicted by poverty, powerlessness, overwork, illiteracy and exploitation. Such afflictions as well could be expected were particularly among the poor creating more imbalances and disparities. The report stressed on the need for special, temporary measures to transform *de jure* equality envisaged in the constitution into a *de facto* one. The recommendations of the CSWI, the guidelines for the World Plan of Action provided at Mexico and a unanimous resolution passed by the Indian Parliament on the Report of the CSWI provided the instru-



mentalities to operationalise women's equality. Women began to emerge as critical group for development from being targets of welfare policies—a shift in approach, clear in our Sixth Plan. Moreover, it recognised women as a group adversely affected in the process of economic transformation. As a result, economic independence, educational advance and access to health care and family planning were accepted as the strategies to be adopted in the Sixth Plan for the advancement of women. This shift in approach from welfare to development and concern for social services sectors represents in India a major achievement of the decade. The first Working Group on Employment of Women (1977-78) and the first cell for women in the Ministry of Labour and Employment (1975) are major landmarks. The ordinance of 1975 which later was enshrined in the Statute Book as the Equal Remuneration Act, 1976 is another landmark.

Information Explosion

The CSWI based its observations on about six per cent of women employed in the organised sector, while the overwhelming majority had to be left out as invisible. Indian Council of Social Science Research (ICSSR) which helped the CSWI in its investigations persisted in the studies and the result was a flood of information about the occupational and employment patterns of women in the unorganised field, in the primary, secondary and tertiary sectors. Information collected by the National Sample Survey was used extensively in the Sixth Plan. In the 1981 census, a new Group, "Marginal Workers" was included which proved, as the CSWI feared, that a majority of poor women was under employed, unemployed or irregularly and marginally employed. All this helped to build up a stronger data base about Indian women.

Social Debate

No less important was the revival of the Social Debate on the status of women, which was virtually forgotten some 15 years before the constitution of the Commission. It helped in generating favourable public opinion. Today the press and other media in addition to academic and legal communities support women in giving voice to their grievances. Women's Organisations are playing an increasingly important role in protesting against and highlighting various crimes and atrocities perpetrated against women. And they have succeeded in generating a dialogue about the problems faced by women, among various concerned agencies.

Women were recognised as a group adversely affected in the process of economic transformation. Therefore, economic independence, educational advance and access to health care and family planning were accepted as the strategies to be adopted in the Sixth Five Year Plan for advancement of women.

The National Committee on Women was constituted in September 1976 with the Prime Minister as Chairperson to ensure a fair deal for women as an alternative to the National Commission recommended by CSWI and the UN World Plan of action. As a nodal point to coordinate policies and programmes, to initiate measures for women's development the National Committee a women's welfare and development Bureau was established in the Ministry of Social Welfare. Special Cells were set up in the Ministries of Labour and Employment and Rural Development to strengthen women's economic participation. The Planning Commission appointed a Working Group on Employment of women in 1977-78 and it encouraged the Ministries of Agriculture and Rural Development to review their programmes and policies to enlarge the participation of rural women in economic activities. They prepared two studies: one on the Development of Village level Organisations of Rural Women and another on the Role and participation of women in Agriculture and Rural Development. The Ministry of Education appointed Special Committee to advise on Adult Education for Women. Appointment of these committees and groups preceded the consideration of a memorandum to the government by the Women's Studies Advisory Committee of the Indian Council of Social Science Research (ICSSR) which recommended steps to arrest the trend of women becoming "dispensable—economically and demographically".

In 1978-79, as preparatory action for the Mid-decade review a series of State level conferences were organised, culminating in the National Conference on Women and Social Development sponsored by the Ministry of Social Welfare in Delhi in 1979. It made specific recommendations for better employment, health, education and political participation of women. It was followed by the First National Conference on women's studies in 1981 which resulted in the formation of the Indian Association for

Women's Studies to promote incorporation of women's issues into teaching and research. A Second National Conference on Women's Studies was organised by the Association recently.

Women in the Eighties

In 1980 a Women's Activists Group submitted a memorandum "India Women in the Eighties". It expressed the fear that the draft Sixth Plan did not contain specific measures for women's development. A dialogue ensued and chapter XXVII on women and development was added to the plan document. The Department of Science and Technology developed a programme to promote women's access to Science and Technology. On the recommendation of a Working Group of the Council for Scientific and Industrial Relations, the University Grants Commission, relaxed the age limit for women scientists who wanted to take up research.

During the decade, the emphasis of voluntary women's organisations has shifted from health, welfare and education to more employment generation for the rural women and poor women in urban areas. Such organisations have been getting liberal assistance from Central Social Welfare Board, Department of Science and Technology and various other Government Agencies. Women's organisations grew in number substantially during these ten years. They showed an increasing degree of concern and protest on violence against women. These organisations have joined hands to demand improvement in the laws for the protection of women. The new and militant women's organisations began to see development not as an end in itself but as an instrument to improve the overall status of women in the family, in the neighbourhood and in the political system. Banks and other credit institutions have now come forward to provide cheap loans, to organise training, to improve productivity, to give technological support and to improve marketing facilities to members of such organisations. An attitudinal change where the emphasis has shifted from doing things *for* women to doing things *with* them, that is a move from charity to participation is much in evidence now.

Intermediaries

The concept of participation has prompted the emergence of a new group of activists termed as "in-

Today, an attitudinal change where the emphasis has shifted from doing for women to doing things with them, i.e., a move from charity to participation is much in evidence now.

termediaries." The intermediaries utilise their assets—education, information and capacity—to extract developmental support from various sources for the benefit of their client groups at grass root level. But their relationship never deteriorate into a patron-client relationship. To promote such intermediaries, the Ministry of Social Welfare started Women Development Centres in selected women's colleges in Delhi.

Research, review and the setting up of the needed administrative infrastructure marked the first half of the decade and this made the issues of women visible to the planners and administrators with discernable urgency. As the decade advanced, new issues cropped up, putting formidable obstacles in the path of the development of women. Increasing crimes against women, resistance of localised power groups to emancipation of women and the limitations of a complex bureaucracy led to the realisation that women's development cannot be achieved merely by benefits flowing from the Government. Grass root level organisations, particularly in rural areas, as forums for women's participation in the developmental process have now been acknowledged. With this in view, a minimum quota has been reserved for women in beneficiary oriented programmes such as Training of Rural Youth for Self Employment (TRYSEM).

We have now realised the roles that government, women's organisations and other institutions can play in the betterment of women. We are now more aware of the processes that marginalise women and brand them as passive, backward and apathetic to change. The success of the effort to make women a really emancipated lot is ultimately in the removal of situational constraints women are subject to through supportive measures and in empowering women to assert themselves in the development process. ○

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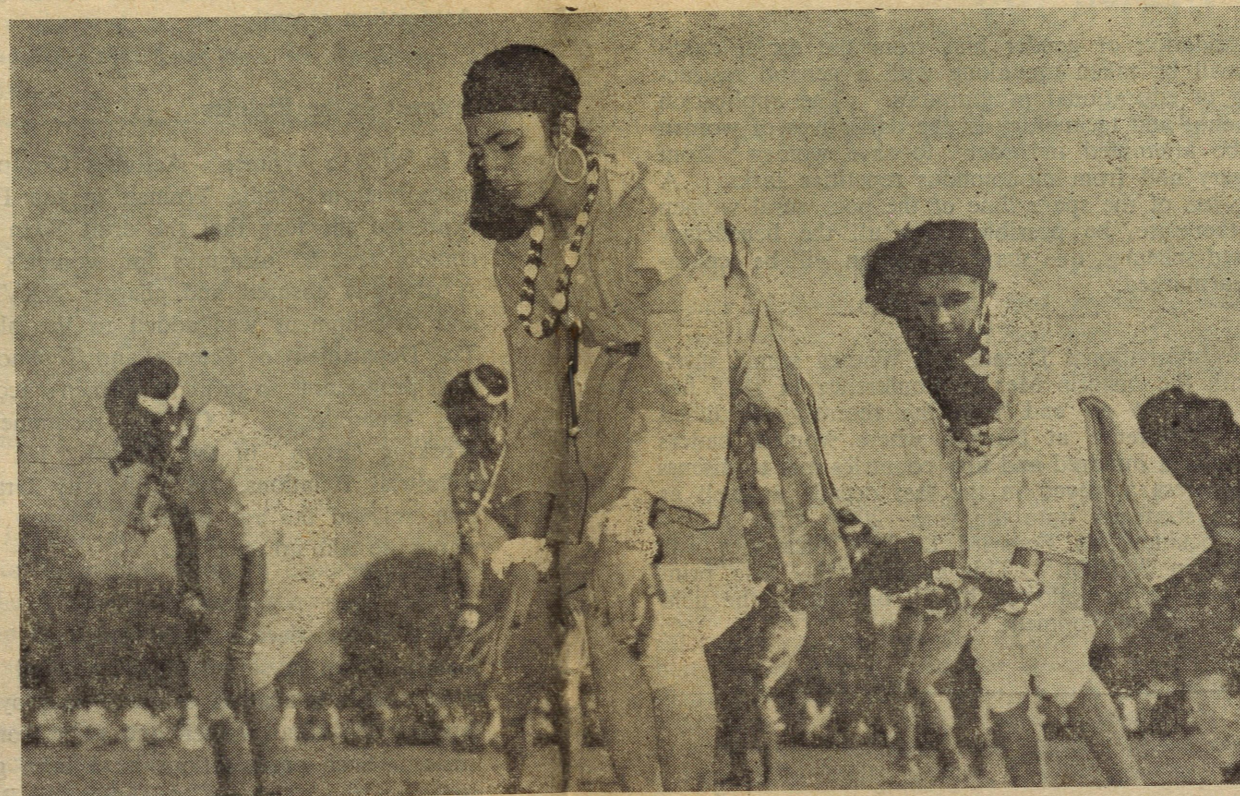
HELPING WOMEN TO HELP THEMSELVES

SMT. MARAGATHAM CHANDRASEKHAR

The development of women is an integrated and unified concept, stretching across economic, social and cultural fields. Thirty three years of planned development in India have done a lot to lift Indian woman from her former subordinate and dependent status. The basic approach in the Seventh Plan is to inculcate confidence among women and bring about awareness of their own potential for development.

IN free India, Truth, Justice, Equality and Fraternity are the four pillars on which the Constitution and our polity rest. In the thirty eight years which have passed since Independence, these glorious ideals have stood by us, even when the country has faced many vicissitudes, whether it be external aggression or internal unrest. We have successfully passed through a trouble-some and crucial testing period. Throughout the country, there is a sense of vibrant confidence and unity.

Women have been given pride of place in the Indian Constitution. To make up for long centuries of neglect and to counteract the ingrained prejudices following from age-old laws like those of Manu and other patriarchical law givers, the Constitution promises Justice, liberty, equality and fraternity to all its citizens. Article 14 ensures equality before the law to all its citizens. Article 15(3) empowers the State to make any special or general provision for women and children, even in violation of the fundamental obligation not to discriminate among citizens, inter-alia of sex. Article 16(2) forbids discrimination in employment under the State on grounds of sex.



The Directive Principles of State Policy enjoins upon the State to ensure right to an adequate means of livelihood for men and women equally.

It is in the Directive Principles of State Policy that the ideals of the Constitution-makers with regard to women's development and protection, can be clearly seen. They urge the State to ensure equal pay for both men and women; to protect the health and strength of women and child workers from abuse and entry into jobs not suited to their strength; to ensure just and humane conditions of work and maternity relief for women.

Many of the ideals enshrined in the Directive Principles have been translated into reality by the Government. The Equal Remuneration Act has assured equal pay to men and women for work of equal value. Supportive services such as creches and maternity benefits have been made available to women working in the organised sector.

The development of women is an integrated and unified concept, stretching across economic social and cultural fields. However, since poverty is the single biggest cause of backwardness, the economic and

socio-economic sectors such as health, education and employment are generally deemed to be very crucial for women's overall development. Thirty three years of planned development in India have done a lot to lift Indian woman from her former subordinate and dependent status. The percentage of literate females to total female population in 1901 was 0.69. In 1981 it was nearly 25 inspite of a massive growth in population.

School education at primary, middle and higher levels has been stepped up considerably in order to cope with the never ending stream of boys and girls who knock at the school portals for admission every year. In a single decade, that is, from 1960 to 1972 the educational budget of the country had increased more than three-fold. The Government has now launched upon an ambitious programme to eradicate illiteracy among women completely by 2000 A.D.

The problem of removing illiteracy among women is inextricably linked with questions of health and fertility. Women suffer from malnutrition, poor access to health care, and poor maternity services. —▷

SOME FACTS ABOUT WOMEN

- According to 1981 census there were 35.4 crore males and 33.1 crore females in the country.
- The sex ratio (number of females compared to 1000 males) which was 930 in 1971 rose to 933 in 1981, that it was 972 in 1901, 946 in 1951 and 941 in 1961.
- During 1971-81, the overall growth rate of population was 25 per cent of which males constituted 24.6 per cent and females, 25.4 per cent.
- Percentage of literates rose from 29.5 in 1971 to 36.2 in 1981. Female literacy percentage rose from 18.7 to 24.8, while male literacy rose from 39.5 to 46.9 per cent between 1971-81:
- 32.2 per cent of girls between 5 and 9 and 37.5 per cent between 10 and 14 were attending schools.
- Female age at marriage rose to 18.6 in 1981 from 17.8 in 1971 and that this is higher than the age of 18 prescribed by law.
- By 1982-83 over 340 lakh couples were protected against the risk of pregnancy by family planning methods and this constituted 28.4 per cent of the eligible couples.
- According to the highest of the three estimates projected by the Registrar General of India based upon Sample Registration System, life expectation at birth was 52.5 years for males and 52.9 for females.

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—> These factors are again linked to lack of economic opportunities. Thus the three main areas of concern to women—health, employment and education—are connected by casual links. Any intervention by the Government in any of these sectors will not give complete results unless, simultaneously action is not taken in the other two.

In the Seventh Five Year Plan, a special thrust is being given on woman's development. Women have been recognised as integral and central to the development process. Hitherto they were subordinated to a marginal position, even in the formulation and implementation of schemes. The special disabilities which women suffer from will be taken care of by supportive services and other special programmes, so that they can take their due place, as equal partners in all development programmes.

Special attention will be focussed on socio-economic programmes, so that the women's earning capacity can be enhanced. The basic approach in the Seventh Plan would be to inculcate confidence among them and bring about awareness of their own potential for development. A multi-disciplinary or multi-sectoral approach would be adopted covering employ-

ment education, health, nutrition, science and technology and related fields. Strees would be laid on creating facilities for women generating activities to enable them to participate actively in development.

Elimination of gender bias from the social curricula will be taken up, along with a general restructuring of educational programmes. The application of science and technology in the daily lives of women will be attempted in order to save women from drudgery and from monotonous repetitive tasks. A better use of the spare time of the poor rural women will therefore, be possible. In all the beneficiary oriented schemes, due share of women will be separately earmarked.

The International Decade for Women which started with the historic Mexico Conference in 1975 has now come to an end with the recently concluded world Conference at Nairobi where women leaders from over a hundred and fifty countries met to discuss the progress achieved in the last decade as well as to plan strategies upto the year 2000 A.D. A historic document on Forward Looking Strategies was adopted in Nairobi. This contains the blue print for action to be followed by all nations in the field of Women's Development. ○

ROLE OF VOLUNTARY AGENCIES FOR WOMEN'S DEVELOPMENT STRESSED

THE Minister of State for Rural Development, Shri Chandulal Chandrakar has called upon the voluntary agencies to come forward to help women folk in organising and in finding suitable income generating activities.

Inaugurating the two-day seminar on the 'Development of women and Children in Rural Areas' (DWCRA) in New Delhi on 18 June, 1985, Shri Chandrakar said that majority of women in rural areas live in poverty, without many opportunities for improving their living conditions. Constitutional rights and guarantees will have no meaning for them, if they cannot even feed and clothe their children properly or send them to school. He mentioned that very recently the Government had taken a decision to provide benefits under the Integrated Rural Development Programme to at least 20 per cent women.

About the scheme of DWCRA the Minister said it is being implemented in 50 selected districts on a pilot

basis. DWCRA, the Minister said, being a production oriented scheme its success depends to a great extent on the marketability of the produce. In this, we are trying to involve khadi and village industries board and other cooperatives so as to increase the return of the produce.

The Minister stressed upon the need to inculcate leadership among women. He said under IRDP and TRYSEM we are training some of the boys and girls to come forward and work closely within their districts. In this regard he referred to the organisation of groups through which the DWCRA is designed to operate.

Shri Chandrakar hoped that we should be able to find new vocations for the ladies which are most suitable for them and bring the women folk forward to take up the task with a greater sense of involvement. ○

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WOMEN

HEALTH AND DEVELOPMENT

The United Nations Decade for Women is really only a beginning, a time to look ahead, to make sure that what progress has been achieved is maintained and that the impetus given by the Decade is not lost.

THE needs and roles of women have captured the attention of the world for the past 10 years, in large part due to the stimulation provided by the United Nations Decade for Women (1976-1985). However, in a report by the Director-General to the Thirty-eighth World Health Assembly, it was noted that general progress has been patchy, with only limited gains at best. The urgent need for concrete strategies and plans is stressed in the report, which also states that awareness of the need for further action is the result of a growing realization that women's health and involvement in health care are keys to achieving health for all.

The status of women is a significant reflexion of the social justice in a society and can be measured in terms of level of income, employment, education, health and fertility, as well as by the roles women play in the family, the community and society. If the status of women is low, if they are ignorant, malnourished, overworked, and bearing too many children from an early age, the health of their families as well as their own health suffers.

In developing countries, where large numbers of people are suffering from the consequences of underdevelopment, women—and that means their children too—are the hardest hit by poverty, famine, squalid living conditions, disease and lack of health care.

Special health needs of women

As the ones who bear and nurture children, women have different and additional health needs to those of men. Maternal mortality accounts for a large proportion of deaths among women of reproductive age in developing countries. In countries where the problem is most acute, rates are as much as 200 times higher than the lowest rates in industrialized countries.

Nearly half of all births take place without the help of a trained attendant, and each year over half a million women die in childbirth. The main causes of maternal deaths are haemorrhage, often with anaemia as an underlying cause, and sepsis. Most of these deaths are avoidable if skilled help is available.

Lack of care also leaves its mark on survivors. Countless women suffer from permanent debilitating conditions such as incontinence, uterine prolapse, genital tract infections and vaginal fistulae which lead to a low quality of life and often to the complete social isolation of the victims.

Uncontrolled fertility aggravates the problems. Too many or too closely spaced pregnancies are dangerous for mother and child and affect the health of other family members, especially very young children. Age at childbearing is also important: births to women who themselves are not yet physically and emotionally mature can permanently injure their health. The chances of dying, for both mother and baby, are many times higher in this age group than for women in their twenties. However, in many countries most girls still marry very young and over half first births are to women under 19. In other countries, dramatic increases in adolescent pregnancies have been seen in recent years.

The ability to plan their reproduction frees women to control other parts of their lives. Yet, currently fewer than half the women who do not want any more children are practising family planning. Lack of availability of family planning services is one reason for this; however there are other obstacles, including social attitudes. In many countries, the value of a woman is based on the number of children she has. She is often dependent on her children in later life for economic and moral support. The situation is made worse by a preference for sons in many societies, which in its extreme form can lead to the abandonment of female children, and much more commonly results in increased fertility.

Despite social pressures to have more children in many countries, women are risking their lives to end unwanted pregnancies by obtaining illegal abortions.

In some Latin American countries, illegal abortions account for 50% of maternal deaths and permanently injure the health of many more.

Cancer is another major health problem for women. Cancer of the cervix is the main form of cancer in the developing world, with half a million new cases occurring annually. In Latin America every year approximately one in every 1000 women between the age of 30 and 55 develops cervical cancer. However, with simple screening, cervical cancer can be detected and treated at an early stage when the cure rate—with minimal treatment—is nearly 100%.

Women as health resource

In most countries the professional health labour force is predominantly female, although women tend to fill the lower paid, less prestigious jobs. Thus, although traditionally the majority of doctors have been men, as many as 75% of health workers are women.

In addition to their contribution in the formal health system, women carry extra responsibilities for health through their contribution to the health of their families and communities. Women are expected to be health educators by teaching sound health practices to future generations, to create a home environment that is conducive to health including the provision of clean water and nutritious food, to make sure their children are immunized and cared for when they are sick, to limit family size despite social pressures to the contrary and to care for the elderly as well. Women are expected to fulfil these multiple roles while being the least educated and informed.

Women in health development

There is striking evidence that the woman's level of education is one of the most significant factors in the health of her children. And yet in the developing world, two-thirds of the women are illiterate. In Africa, only 15% of women can read and only one quarter of girls attend school beyond age 11.

Women's contribution to the economy is grossly underestimated and is not reflected in labour force statistics. Globally, women are responsible for at least 50% of food production; in some countries and regions the figure is much higher. In addition to the time spent on crop cultivation and harvesting, twice as much time can be taken by food-processing and

preparation—tasks carried out almost exclusively by women. Similarly, women spend a great deal of time and energy fetching fuel and water (often involving a walk of 10 km three days out of four) in addition to the many hours that they devote to housework. The result, according to the International Labour Organisation, is a working week of 70-80 hours for many Third World women.

The continuing breakdown of traditional societies also often aggravates the situation of women. As a result of urban-based development, migration of husbands, wars, and desertion, the proportion of women left to cope alone, with very few resources of skills, is increasing rapidly in many rural areas and among the urban poor in both developed and developing countries. This is reflected in the statistics on female-headed households, which in some countries seem to form the large majority of the poorest families. For example, an analysis in a large developing country showed that 40% of all female-headed households were in the lowest income group; the corresponding figure for male-headed households was 21%. In addition, male heads of households often earned less than 50% of the household's total income and depended on women and children to contribute the rest by working in the informal sector without the social or other benefits resulting from formal employment.

Policy implementation

Many countries have enacted legislation and policies that are aimed towards the advancement of women by guaranteeing equal rights, social security and maternal benefits. Often women are not informed of their rights and have no means of asserting them.

The gap between legislation and its implementation is large. Few resources have been made available for this purpose, and rarely are effective mechanisms in place. Social attitudes continue to be a major obstacle to progress. The underlying assumption in many countries continues to be that the difficulties encountered through the combination of motherhood and work are to be borne solely by the individual woman.

WHO's Executive Board recommended in January of this year a resolution calling on Member States to intensify their concern about women both as recipients and providers of health care, and to promote women's health and their wider participation, particularly as decision-makers, in health and socio-economic development. ○

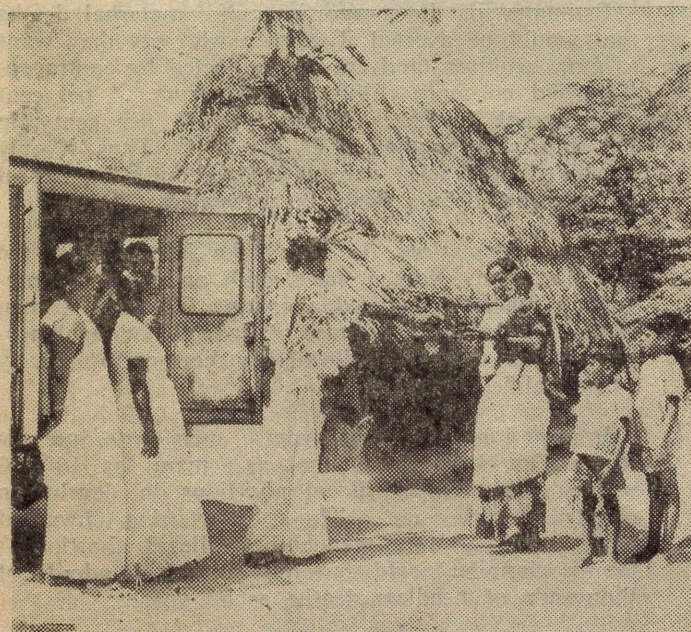
Swasth Hind

In Africa and Asia up to a quarter of all deaths to women of childbearing age occur in childbirth—largely unremarked by governments or the medical profession. This crisis of maternal mortality has received little attention during the UN Women's Decade which reaches its climax at a world conference in Nairobi held in July, 1985. Here, a leading expert in family health at Columbia University explains why greater efforts to help women avoid unwanted pregnancy could save hundreds of thousands of lives.

MOTHERS IN PERIL

—A Decade of Silence

DEBORAH MAINE



December 1985

THE United Nations Decade for Women was dedicated to the promotion of the rights of women. Yet the fundamental rights to reproductive health and reproductive choice remain far removed from a large proportion of women in the Third World.

In all the talk about women's needs, little attention has been paid to maternal mortality during the decade. For most countries only scraps of information exist on this subject. But even from these, we know that far too many women are dying as a result of childbirth. They have died unnoticed by their governments and often by the medical profession too.

Studies in Africa and Asia found that one quarter of all deaths among women of childbearing age were due to maternal mortality. In the United States, in contrast, less than one per cent of deaths among women aged 15-49 are maternal deaths.

Just as tragic as the sheer number of maternal deaths is the fact that many women are dying as a result of pregnancies they did not want.

The World Health Organization gives the regional ranges for maternal mortality as follows: Latin America, 16 to 468 deaths per 100,000 live births; Asia, 7 to 1,000; Africa, 160 to 1,100; and North America, 7 to 15. Thus in poor countries, maternal mortality rates (MMRs) are probably 10 to 100 times as high as in industrialized countries.

Such ranges are too wide to be meaningful. We can, however, narrow them down by looking at available information critically. Very low reported rates of maternal mortality in developing countries are usually government estimates, and these are notorious for being too low.

For instance, a survey of deaths in the Egyptian governorate of Menoufia produced a maternal mortality rate of 190 in 1980-1982. The Egyptian Government's own most recent national estimate (for 1978) was 82 deaths per 100,000 births—less than one-half that found by the survey.

Some of the highest rates cited (of 1,000 or more) are probably not reliable either. Such extremely high rates usually come from studies of births and deaths in large hospitals. The problem with these studies is that in poor countries most women deliver at home unless they develop complications. Consequently, problem deliveries are over-represented in hospital data, and the mortality rates are too high.

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Community surveys should give a more accurate picture. These are uncommon but a few have been done. For example, community studies in urban Ethiopia and rural Ghana yielded maternal mortality rates of 350 and 400, respectively. Rates of 500 to 700 are reported for Senegal.

A maternal mortality rate of 500 means that, on average, every birth carries a 1 in 200 chance of death. But that is only the one-time risk. If a woman has 10 children (as many African women do) then she runs this risk 10 times. Her lifetime risk, therefore, is at least one chance in 20 of dying as a result of pregnancy or delivery. To take a more moderate example, in an area when the MMR is 350, for a woman who has six children (the average in Africa), her chance of maternal death is 1 in 50.

Maternal mortality is higher (and under-reporting of deaths greater) in Sub-Saharan African than in other parts of the Third World. Nevertheless, the general point holds for other regions: maternal mortality is still all too common in developing countries.

Exhortations to improve maternal and child health are common at national and international meetings, but specific measures to reduce the tragic toll of maternal deaths are rarely discussed.

One reason for this might be that maternal mortality (unlike infant mortality) may not be greatly reduced by community-level and preventive measures. Without access to surgical services there may be no way to save the lives of many of the women who haemorrhage or develop obstructed labour (two of the most common complications).

In the Third World, most women still deliver their babies at home, and go to the hospital only (if ever) when they have serious complications. According to WHO, in Latin America more than one-third of women give birth without the help of any trained health worker. In Asia this is true of half of all births, and in Africa the proportion rises to almost three-quarters. Furthermore, in a great many communities, there is no place to go for medical care when serious complications do arise.

Providing proper obstetrical care for all women is an important goal to work for. Unfortunately, judging from the last decade, reaching that goal will be neither easy nor quick. In the mean time, what can we do to prevent maternal deaths in the Third World? One comparatively straightforward way is to help women avoid unwanted pregnancies.

A substantial proportion of married women in developing countries have already had all the children they want. The World Fertility Survey which looked at the situation in 42 countries found that the proportion of women who say they want no more children varies from 12 per cent in Ghana to 61 per cent in Colombia and Sri Lanka. The average is 40 per cent.

Even in Sub-Saharan Africa where women want large families the proportion is sizeable among older women and those with a number of living children.

For whatever practical or cultural reasons, many of these women are not currently using an efficient method of contraception, such as the Pill or an IUD. The proportions of women who are exposed to the risk of pregnancy, and want no more children, but are not using an efficient method of contraception ranges from 46 per cent in Egypt to 85 per cent in Lesotho. The average is 74 per cent.

In short, there is considerable unmet need for contraception in developing countries. Four in 10 currently married women say they want no more children, but the great majority of them are not protected against unwanted pregnancy.

The reasons why so many of these women are not using contraceptives are varied. There may be no services available, or services may be too costly or far away. More subtle barriers also play a part, such as familial pressure to have more children, insensitive behaviour on the part of clinic staff, or fears about the effects of contraception.

Whatever the barriers, we need to identify and remove them. Until this is done, women do not really have the freedom to decide the number and timing of their pregnancies that has been promised to them.

If most unwanted pregnancies were avoided, we could expect the effect on maternal mortality to be considerable, especially since the proportion of women who want no more children rises steeply with age and with the number of living children.

This is important because older women and women who have already had many children are also more likely to die as a result of childbirth than are women in their twenties and those who have only had two to four children.

Estimates of the proportions of maternal deaths that would be averted if women who say they want to more children (and are not protected by contraception) had no more children, range from 14 per cent of maternal deaths in Khana to 42 per cent in Pakistan. The median is 24 per cent. Thus, if only unwanted pregnancies were averted, about a quarter of all maternal deaths might be prevented.

These calculations do not take into account the fact that many women, faced with an unwanted pregnancy, resort to induced abortion. To most women in the Third World, because of financial or legal problems, this means an illegal abortion performed by an unqualified person.

Information on deaths from such procedures is scarce. One estimate is that as many as 168,000 women may die of illegal abortions in developing countries every year. Thus, by averting unwanted pregnancies—and, consequently, illegal abortions—family planning could certainly prevent hundreds of thousands of needless deaths each year.

People News/Features

Swasth Hind

Development of Women and Children in Rural Areas

The objective of the scheme is to focus attention on the women members belonging to the target group. This would enable them to increase their income besides providing supporting services to take up income generating activities. The scheme assists individual women to take advantage of services already available under IRDP and also helps in organising women in homogenous groups to take up work on group basis. It also provides supportive services to women of the target group in the form of working conveniences and suitable appliances to improve their efficiency.

The scheme organises child care facilities while the mothers are at work. A provision of Rs. 5000 is made for each block for creating temporary child care facilities at the NREP work sites for the duration of the work. This may include a temporary structure, water cans for drinking water, cradles, food and medical care for the children. Gram Sevikas may impart some education to rural women on child care and nutrition as well. In order to implement the scheme the areas are selected on the basis of backwardness, incidence of child mortality and level of literacy.

—Kuruksheeta, April, 1985.

BY THE YEAR 2000 THERE WILL BE MORE WOMEN THAN MEN

By the year 2000, there will be more than three Billion women, out-numbering men by 175 million, but, according to the UN Fund for Population Activities (UNFPA), women are unlikely to experience any increase in political power.

The Fund's "State of World Population Report 1985" says that is because women constitute the majority of the poor and 60 per cent of the illiterates.

While the number of illiterate women is expected to decline by five million in the richer countries by the end of the century, it is likely to increase worldwide from 491 million to 552 million, mainly in Asia and Africa. The Executive Director of UNFPA, Mr. Rafael Salas, blamed the demands of childbirth and child-bearing for the denial of education and training to hundreds of millions of women and for their exclusion from political and economic decision-making.

Higher education generally leads to higher rates of contraception use, and, the report states, the "guarantee of reproductive freedom is basic to women's participation in productive activities and to their economic freedom".

Women in developed countries are able to control their own fertility and work for more participation in the decision-making process, but an improvement in the status of third world women, the report says, is held back by the denial of reproductive freedom.

Linking the use of contraception to female educational and socio-economic status, the report says that such use varies widely—from almost none in much of Africa, for example, to 71 per cent in Singapore. One third or more of women in Latin America and 60 per cent of those in China practised birth control but "there is a long way to go", the report said. ○

— U.N. Weekly News letter 6 July, 1985

INTERNATIONAL DRINKING WATER SUPPLY

AND SANITATION DECADE INDIA : 1981-1990

WOMEN'S ROLE IN THE WATER DECADE

AVERTHANUS L. D' SOUZA

SOME of the projects which are ostensibly meant to promote "women's development" reveal a tendency to consider women as an inferior species in need of development. Many women themselves, unfortunately, fall victim to this erroneous assumption that women, more than men, are in need of special programmes of "women's development". Such programmes are, in fact, a perpetuation of the system in which women have been viewed as mere targets of welfare policies.

The reality is that cultural norms, and consequently, social mores effectively preclude the important contribution that women can make to the overall development process.

Mahatma Gandhi had asserted that the future India could not be built without the willing and conscious participation of one half of its population—women. In spite of this, their contribution has been limited to the fields of health, education and social services.

It is only in the Sixth Five Year Plan period (1980-85) that there is official recognition of the vital role of women in economic development in areas such as agriculture, rural development, land rights, forestry, and access to training for independent economic activities.

Women and the Water Decade

Recognizing the impact which women can have on the success of water and sanitation programmes, the United Nations Conference on Human Settlements (HABITAT) and the United Nations Water Conference adopted special resolutions recommending women's incorporation in these programmes. In addition, the 1980 World Conference on the UN Decade for Women adopted a resolution which specially mandated "Member States and UN agencies, including specialized agencies, to promote full participation of women in planning, implementation and application of technology for water supply projects." At its tenth meeting held in April 1982, the Steering Committee for Cooperative Actions to support the IDWSSD (International Drinking Water Supply and Sanitation Decade) decided to establish an Inter-

Agency Task Force on Women and Water. A paper entitled "Strategies for enhancing Women's participation in Water Supply and Sanitation activities" was developed. The paper emphasized the integration of women's participation as part of the general efforts in water supply and sanitation activities. It urged that no new parallel structures for women's activities be created and that women's participation should not be viewed in isolation from government or international agency activities. It suggests areas for action as part of the IDWSSD activities. The strategy envisages involving women at the policy making, management and technical levels for the programming, monitoring and evaluation of existing or future Decade activities.

Women are more than target groups; they are active agents who can contribute to the Decade efforts by decision making, generating ideas in policy, mobilizing labour, providing resources and disseminating and implementing innovations.

The emphasis on women's participation does not imply that activities should be carried out exclusively by women. It stresses, rather, the need for both men and women to work together as partners. Experiences have shown that women as primary users and managers of water resources, and as the principal influence on family sanitary habits, can contribute a great deal to the better planning, functioning and utilization of the improved facilities when provided with appropriate training and support.

Situation of women in India

Already in 1971, the Government of India had constituted a "Committee on the Status of Women in India" (CSWI) to undertake a "comprehensive examination of all the questions relating to the rights and status of women" in the context of "changing social and economic conditions in the country and new problems relating to the advancement of women."

A National Committee on Women was constituted in September 1976 under the Chairmanship of the Prime Minister. During 1977-78, when exercises began for the Sixth Five-Year Plan, the Planning

Since women are the traditional water carriers, they spend a considerable amount of their time—often upto six hours a day—hauling water over long distances. By virtue of their domestic functions women are particularly vulnerable to water-related diseases, which account for 80 per cent of all illness, says the author who is a consultant with the UNDP for the International Drinking Water Supply and Sanitation Decade.

Commission appointed the Working Group on Employment of Women, and also encouraged the Ministries of Agriculture and Rural Development to review their programmes and policies so that women's needs and aspirations were incorporated within their development activities planned for the rural areas.

The National Conference on Women and Development which was held in Delhi in May 1979 made specific recommendations for the participation of women in the fields of employment, health, education and political activity.

A review of the health status of women after four Five-Year Plans showed that there were several persistent problems which were responsible for the unsatisfactory health status of women. Among these were:

- (a) Malnutrition—caused by poverty, over-work, repeated pregnancies and her lower educational and social position.
- (b) High gender differentials in access to health care services.
- (c) Inadequate development of primary health care and preventive health services, particularly in the rural areas.
- (d) Inadequate development of maternity and child health services.
- (e) Poor availability of women health personnel, specially in rural areas.

Since women are the traditional water carriers, they spend a considerable amount of their time—often upto six hours a day hauling water over long distances. By virtue of their domestic functions women are particularly vulnerable to water-related diseases, which account for 80% of all illnesses according to estimates of the WHO.

Despite their crucial role in this area, women are excluded from the planning and implementation of water and sanitation projects even though it is they

who often determine a project's success or failure. For example, because of the unacceptable taste of safe groundwater, many women prefer to go back to the traditional water sources—polluted open wells or ponds. A survey in Bangladesh carried out in December 1976 revealed that sanitary latrines are used primarily by women, as they felt the greatest advantage in having the latrines installed close to their houses. It is the women who have to take care of the needs of their children and any aging housebound relatives. On the other hand, an example of inappropriate design arising out of the failure to involve women in the process of designing is provided by a project where the women refused to use the latrines because their feet could be seen from the outside.

Need for Revising Plan Strategies

There is urgent need to take a fresh look at the planning processes to remove the biases against women. According to a recent document published by the Ministry of Social and Women's Welfare, Government of India, there are numerous examples of such anomalies in the Five Year Plan. Areas of critical importance to women namely health, drinking water, education were less than one per cent of planned expenditure in the Sixth Plan. Roads got more than two-and-a-half times the expenditure on health. Yet, any articulation by women reveals health to be a priority over roads.

Elementary education which is critical for any improvement in the status of women is another neglected area. As against an allocation of Rs. 1,165 crores for rural roads, elementary education got only Rs. 919 crores. The Steering Group on Elementary Education for the Seventh Plan pointed out that 95% of this amount would cover only teachers' salaries leaving little for educational equipment or activities, let alone innovations in syllabus.

Of the total resources invested in development during the Sixth Plan, elementary education and rural health combined received only 0.8 per cent of the total investment.



It is important that women health personnel are trained to provide health care, especially in rural areas.

Further analysis of development expenditure reveals that where poverty is pervasive, the perception of needs and priorities is generally a male perception.

Participatory Development

The UN sponsored International Women's Decade has provided the opportunity and the forum for women to become involved in the processes of planning, administration and determination of objectives. One of the important achievements of the Decade has been the realization that women are not merely recipients of benefits flowing from the Government, but that they are partners in the endeavour to remove

poverty and promote development. Over the decade, there has been a rapid growth in the formation of voluntary women's organizations—varying in their ideology, size, focus and financial status. Including village level institutions, there are approximately 50,000 women's organizations in India empowering women to improve their situation and enabling them to articulate their needs and aspirations and to demand full participation in the shaping of development decisions.

This is what the Father of the Nation had in mind when he invoked the time "when women will begin to effect the political deliberations of the nation". ○

Swasth Hind

THIRTY-EIGHTH SESSION OF THE WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA



HEALTH IS THE STARTING POINT OF HUMAN WELFARE

— SMT. MOHSINA KIDWAI

The thirty-eighth session of the WHO Regional Committee for South-East Asia was held from 24—30 September, 1985, in New Delhi. The seven-day session of Regional Committee was attended by senior health administrators and Officials from Member Countries of the Region—Bangladesh, Bhutan, Burma, Democratic People's Republic of Korea, India, Indonesia, Maldives, Mongolia, Nepal, Sri Lanka and Thailand. Representatives from other United Nations agencies and several non-governmental organizations in official relations with WHO also attended the meeting.

Smt. Mohsina Kidwai, Minister of Health and Family Welfare, who was the Chief Guest, inaugurated the Session.

In his address, the Regional Director of the WHO South-East Asia Region, Dr U Ko Ko, praised India's efforts for socio-economic development.

The Regional Director also referred to the steady progress made in the field of health by all the eleven Member Countries of the Region despite heavy odds.

In his address at the inaugural session, the WHO Director General, Dr H. Mahler, paid rich tributes to the memory of Mrs Indira Gandhi under whose inspired leadership the Government prepared a development plan for its people in which the promotion of health and the prevention of disease played prominent parts.

We publish here excerpts from the inaugural address delivered by Smt. Mohsina Kidwai.

OUR happiness and prosperity depend, to a large extent, on our state of health. To my mind, health is the starting point of human welfare—as much for the individual as for the Nation. If we want to improve the quality of life of our people, we have to make them healthy and keep them healthy—not in the narrow sense of their being free from disease but in the broader sense of creating an environment of physical, mental and spiritual well-being in which every person is enabled to realise his best. This is the goal that we have set for ourselves and our effort should be to achieve this objective following an integrated approach in which Health and Family Welfare are inter-woven in our overall developmental strategy. Within the sphere of health and family welfare also, the various programmes and activities including family planning, maternal and child health care, control of major communicable and other diseases, prevention of diseases through better personal and environmental hygiene, health education, etc., should be suitably inter-linked. All these activities are mutually reinforcing and our success would depend on how well we are able to pursue them as part of a broad system.

We are aware that there is no quick and easy solution to the problems we have to contend with, in our efforts to improve the quality of life of our people. Of late, we have been repeatedly referring to the need for strong political commitment, strengthening of the national ministries of Health, securing inter-sectoral coordination, mobilizing community support with a view to raising the health status of our people. While all these are highly relevant aspects and integrally inter-related, we must decide as to what comes first, where do we begin? We must know what exactly to commit, what to coordinate and whom and how to involve. This would require a great deal of preparatory work, collection and collation of health information and vital statistics for the territorial units of our countries, an objective analysis of our existing approaches and programmes, evaluation of the results achieved so far and the gaps noticed. The existing educational and training patterns would need to be overhauled. There is urgent need to review the existing delivery systems and the efficacy thereof, cost effectiveness of the technologies used to deliver programmes and services, relevance of the existing technical and managerial patterns and arrangements for meeting the present and future objectives.

Family planning—Key to betterment

The family planning programme in India is taken as a key to every individual's and every family's betterment and aims at total human resources development. We realise that poverty cannot be effectively combated unless size of the family is limited to enable each child to have adequate share of resources and opportunities. An unplanned and uncontrolled growth in our population will not only strip the resources required for our national deve-

lopment but may also lead to avoidable social tensions. This is true of almost all developing nations facing the problem of over-population.

Our overall strategy for bringing about rapid improvement in the maternal and child survival rates, which are essential components of Health for All goals, envisages intensified efforts in our programmes of immunization against preventable childhood diseases, prophylaxis against anaemia and blindness, oral rehydration therapy, coupled with improvement in nutritional standards, provision of safe drinking water, aseptic deliveries, etc.

While it is necessary to expand the infrastructure for the delivery of health and family welfare services, it is equally vital to optimise its utility through more efficient organization and management of the programme. We are strengthening supervisory control mechanisms. Staff structure at various levels is being streamlined and large-scale training programmes are planned with a view to improving the functional efficiency of various categories of personnel.

Control/eradication programmes

We have initiated various measures for the control of tuberculosis, leprosy and malaria which affect a large segment of our population. As a result of these efforts, we have succeeded in bringing down the incidence of malaria from over 6 million cases in 1976 to less than 2 million cases in 1984. However, the total number of malaria and *P. Falciparum* cases continue to cause concern to us. We are undertaking an indepth evaluation of our malaria control strategy and would make necessary alterations in the strategy in the light of the evaluation analysis.

Tuberculosis presents a problem of fairly large magnitude in India with over a million cases being detected every year. Treatment facilities are being augmented and 360 TB Centres, 309 TB clinics and over 45000 TB beds have been made available for treatment of TB patients. Similarly the measures for control and eradication of leprosy are being pursued with greater vigour by ensuring early detection and providing regular treatment for leprosy cases. Multi-drug regimen for treatment of leprosy has been introduced in a number of areas where incidence of the disease is comparatively high.

We have achieved considerable progress in Guinea-worm eradication programme. Out of seven States in the country which were endemic at the time of launching the programme in 1979, one State is completely free from the disease and as a result of sustained efforts in providing safe drinking water to all the problem villages, we hope to eradicate this disease by 1990.

Practitioners of traditional systems of medicine namely Ayurveda, Siddha and Unani are providing health care services to a large segment of population

in the rural and unserved areas of our country. We have established a network of colleges, hospitals and dispensaries of these systems and are planning to strengthen them further. I hope that the WHO would continue to provide necessary support and recognition to these systems of medicine. Since India happens to be one of the few countries where traditional systems of medicine are well developed and run on scientific lines, we would be happy to extend cooperation to other member—countries willing to learn about these systems.

Technical cooperation among developing countries in health and other related areas has been discussed time and again by the Health Ministers of South-East Asian Nations as well as invarious international forums. We have always offered to share our resources for training of health manpower of various categories. We are also willing to extend cooperation in other health related fields such as production and quality control of drugs and vaccines to other developing countries.

Voluntary Organisations

In the face of severe constraint of financial and technical resources, the developing countries find it extremely difficult to provide health services through governmental sources alone. A number of non-governmental/voluntary organizations are doing useful work in the health field in our countries and are ready to supplement our efforts. Their potential and supportive role needs to be fully exploited. With a view to involving non-governmental/voluntary organizations in the health programmes, particularly the family welfare programme, we initiated a dialogue at the national level with representatives of these organizations which culminated in a National Conference of voluntary organizations held in New Delhi on 4 September, 1985. The Conference reached a consensus on developing an approach to promote family welfare through voluntary efforts particularly in the rural areas, urban slums and unserved areas. It was agreed that this would require interministerial cooperation for providing necessary support to the voluntary organizations. Keeping in view the recommendations of the Conference, it has been decided to:

- (a) constitute a high-level Standing Committee consisting of the Ministers concerned with Social Welfare, Health and FW, Education and other

extension schemes to formulate a policy for integrating family welfare programmes with other developmental activities;

- (b) set up an Implementation Committee of the Secretaries and other senior officials of these Ministries/Departments to ensure implementation of the policy decisions;
- (c) constitute a Standing Committee for supporting voluntary action in family welfare at the grass-root level and to provide consultancy services, identify voluntary organizations which can promote family welfare in unserved areas and sanction schemes for financial assistance; an amount of Rs. 2.5 million has been set apart for implementation of schemes to be recommended by this Committee;
- (d) place a rolling fund of Rs. 5,00,000 at the disposal of Family Welfare Association of India for inducting more NGOs in the family welfare programme;
- (e) allow voluntary organizations engaged in activities other than family welfare to use a certain amount of money upto 5% of the total expenditure on the family welfare programme;
- (f) institute awards at the rate of Rs. 1,00,000 and Rs. 50,000 to be given to voluntary organizations and voluntary workers respectively in recognition of their work in the family welfare field.

We are confident that the above measures will help us in ensuring people's involvement and support in the family welfare programme at the grass-root level.

While the WHO, under the dynamic leadership of Dr Mahler has succeeded in securing the necessary commitment of the international community to the cause of health for all, and in mobilising financial and technical support, it is for us to take advantage of this favourable climate. The presence of Dr Mahler shows his keen concern for the health and well-being of the peoples of this Region and I am sure he would continue to extend his helping hand in our fight against disease, hunger, malnutrition and increasing population. Dr Ko Ko and his team has been ably assisting us in our common endeavour to achieve the health for all goal and I thank him for the support he has provided to the countries of this region." ○



"My Life is My Message"

TRUTH
AHIMSA
PEACE
LOVE
TOLERANCE
FEARLESSNESS
EQUALITY
SIMPLICITY
SWADESHI

For Gandhiji, these were not mere words or symbols. They were the touchstones of his every action, every deed. That turned his life a quintessence of human values and his every utterance, truly a message. ●

**a message that shall
inspire us forever**



dayp 85/244

THE CRUCIAL DECADE

ANNIVERSARIES and commemorative days often come as uncomfortable reminders of work left undone. 1985 marks the end of the Women's Decade (a mid-point in the decade following the year of the Child) and the end of the Year for Youth. The 10 years globally dedicated to the woman's cause have passed without adequate recognition of the decade that counts most in any woman's life: the one that begins at the moment of birth, and brings the girl child—with luck—to the age of ten. For many, that first decade is never completed.

Social attitudes that govern child care continue to condone the loss of unwanted daughters in infancy, in early childhood, in the years before they begin to appear on the balance sheets of the women's movements. A frightening index of these attitudes hides in the records of paediatric wards and child clinics. Boys persistently outnumber girls in the admissions and outpatients. Why? Not be-

cause girls are healthier—in India they are not—but because sons are brought for treatment. The services are not discriminatory; society is. Sons are breast-fed longer, given more of the family food, valued more. Daughters are still 'liabilities' and only the strongest of them struggle on.

Ending with the year for youth, the Decade leaves behind its unresolved questions. What became of the infant girls born in Women's Year? Those who have survived the decade are 10 years old now—how are they faring? Those who were five when the Decade began are teenagers now, within the 15 to 25 age group of Youth Year. What manner of people are they?

Looking back on 1975, and the climate it sought to create for women's equality and development, we see these questions; looking ahead, we see them still.

—UNICEF

Improved Womens Status to Curb Birth Rate

IMPROVING the status of women through education and employment will help reduce fertility rate in the Asia-Pacific region, according to a report approved by an ESCAP working group.

The report by the second Committee of the Whole for the 41st session of the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), likewise noted that many countries in the region still lack fully integrated population and development policies.

Committee II also considered reports in such sectors as integrated rural development, food and agriculture and shipping, ports and inland waterways. The reports will be forwarded to the Commission's plenary session for final adoption.

Adolescent population in the ESCAP region has been relatively high, said the report, adding that the impact of such a population would be large growth in spite of the introduction of fertility control measures.

The report said that fertility rate in the region has been rapidly declining, but it is still far above the replacement level, a goal set to be achieved by the year 2000 under the Colombo Declaration of the Third Asian and Pacific Population Conference. Replacement level means the number of children born will be just enough to replace their parents.

It urged, among other things, raising female literacy rates, providing rural women with adequate credit, increasing their training and employment opportunities, and raising women's marriage age.

On integrated rural development, the report said that with nearly 70 per cent of the total 2.6 million peoples in the ESCAP region living in the rural areas, adequate attention must be paid to easing the burden of rural poor.

To eradicate rural poverty, it endorsed the so-called integrated approach to countryside development. This approach features people's participation, mobilization of local resources, decentralized decision-making and promotion of self-reliance.

— U.N. Weekly News letter 20 April, 1985

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