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Women Health issues and Women Consumers

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Women Health issues and Women consumers*

Women are the greatest asset of the society and the nation. Empowerment of Women in Health and Consumer aspects may lead to a better health status. It was only from the Sixth Five year Plan onwards that women secured a special role and space in the national plans and planning process primarily with thrusts on health, education and employment. The Seventh Five year Plan aimed at raising health consciousness among women. The Eleventh Plan seeks to reduce disparities across regions and communities by ensuring access to basic physical infrastructure as well as health and educational services. Poor health has repercussions not only for women but also to their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman’s health affects the household economic well-being, as a woman in poor health will be less productive in the labor force. Because of the wide variation in cultures, religions, and levels of development among India’s states and union territories, it is not surprising that women’s health also varies greatly from state to state.

In the year of 2001, there was more initiative towards the empowerment of women by introducing National policy for the empowerment of women. The one of the goal and objective of National policy for the empowerment of women (2001) is to equal access to women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office etc. In that perspective, SELF HELP GROUPS (SHG’s) also opened new

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roots. Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. A SHG is a small group of persons who come together with the intention of finding a solution to a common problem such as Health and medical issues, livelihood generation or watershed management, with a degree of self-sufficiency.

The SHG is a small homogeneous group organized with an objective of improving the socio-economic condition of its members through fair means\(^1\). Andhra Pradesh alone has about half of SHGs organized in the Country. The SHGs are also popularly called DWCRA Groups, and this name became popular after the DWCRA programme (Development of Women and Children in Rural Areas) through which women’s groups were assisted initially\(^2\).

The Agencies organizing SHG’s are non-government organizations (NGO’s), local government departments, banks. These agencies assumed the role of organizing women SHG’s across India. The Swayamsidha Scheme is one of the scheme aims at developing strong pressure groups for women's rights, strengthening and institutionalizing saving among rural women and their control over economic resources, improving access to micro-credit and involvement of women in local planning and convergence of different agencies for women's empowerment and integrated projects.\(^3\) It was the step by Swayamsidha Awareness Camps and Basic Training programmes created awareness among Self Help Groups (SHG’s) members on issues such as Family planning, health and nutrition of pregnant women, child care, issues of adolescents, need for immunization of children, problems of HIV/AIDS, to name a few. They know the importance of health care, family health, reproductive health etc. Some groups

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\(^1\) “SELF HELP GROUPS IN INDIA” available at http://www.policy.hu/nagy/SELF%20HELP%20GROUPS%20IN%20INDIA.pdf Page No.1 (Last visited on Jan 13\(^{rd}\), 2010).


participated in Pulse Polio, Immunization, and Awareness programmes. When it comes to health, women have their own health issues that deserve special consideration. There are certain women’s health related issues and problems that covers everything from reproductive health to mental health. There are certain pathetic conditions of the Primary Health Centres in the remote villages in our country. Primary Health Care includes in the least, health education, promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs.

Illiterate and innocent people especially women fall prey to such compounders and nurses who step into the shoes of doctors without knowing anything properly and without any fear. Sadly, such incidents taking place in the rural areas are not reported and are easily forgotten by the society. Women are not even aware of their rights under the Consumer Protection Act and other laws and unnecessarily, they became the victims in such shabby and unforgivable manner.

The campaign for women’s health and health-rights in India has been primarily geared towards the demand for better health services and facilities, protests against coercive tactics that endangers women’s health and their human rights, and demand for overall well-being of women. Right to life is considered one of the fundamental rights, and health is one of the vital indicators reflecting quality of human life. In this context, it becomes one of the primary responsibilities of the state to provide health care services to all its citizens. Although programmes are being constantly reviewed and revised, the problems persist and continue to worsen.

For instance, the ratio of hospital beds to population in rural areas is fifteen times lower than that for urban areas. Similarly, a pregnant woman from the poorest quintile of the population is over six times less likely to be attended by a medically trained person during delivery. In addition, per person government spending on public health in rural areas is seven times lower as compared to the urban areas. Even though, the National
Rural Health Mission (NRHM 2005) launched in certain states that were identified as having poor health indicators emphasizes on comprehensive primary health care for the rural poor. The main goal of the mission is to provide for effective health care facilities and universal access to rural population.

The trend of reduced public investments and expenditures in health care is forcing people to increasingly access healthcare from the private sector.

**Availability, Accessibility and Quality to Health Care**

F, a woman from a Delhi slum, was suspected of having cancer of the uterus and needed to be examined immediately. She went to an esteemed Public Hospital in South Delhi for the same. She first had to stand in a queue to get a stamp on the OPD card. By the time the doctor arrived, a large number of women were already waiting. Most of them appeared to be from a lower socio-economic category. A lot of them had come from far off places and were not familiar with the processes of the hospital, which left them at the mercy of nurses and peons who shoved them around.

With great irritation, the doctor called out names one by one and attended to them. There was no privacy at all and all sorts of questions were posed to them and they were publicly rebuked too.

F was attended to after a long hour of waiting, and she was asked to have a pap smear. However, no pap smear bottles were available in the ward. The nurse told her that there were only four bottles and they had been already distributed. F was asked to come the next day.

She left and came back the next day for the pap smear. After a long waiting, the smear was taken and the bottle needed to be deposited in another room, before which F had to stand in queue to pay Rs.10 at the cash counter. She was asked to come back after a week for another test and after ten days for the result of the pap smear. She went back for the next test, and the doctor who was to conduct was away on an emergency surgery. She

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received the reports after a week and they turned to be positive. Her treatment however did not start on the day she went to collect her reports, for which she had to visit the hospital again.

The above case provides a vivid example of the poor health care system in India and the pre-existing inequality in the healthcare provisions.

**Lack of Basic facilities:** A woman in Chidika village of Andhra Pradesh\(^1\), developed pregnancy related complications. Since there was no transportation facility from that village, people had to carry her on a cot to the health centre in the nearby town. It took two hours to reach the health centre. By the time she reached the health centre, there was no staff available to attend her immediately. The woman was in critical condition and died.

The above case study illustrates the situation of health services in our country which lag behind in providing basic facilities and accessibility to women during pregnancy. India accounts for the second highest maternal mortality rate in the world.

Access to healthcare is becoming increasingly difficult for a growing number of people because of the continued apathy of the government to recognize health and healthcare as a national priority, along with the legitimization of an unregulated private sector. Firstly, access to healthcare is affected by physical, financial and socio-cultural factors. Further, access to services has to be seen in terms of its coverage, availability of diagnostic facilities, medicines, surgical care and quality. However, cost of care is an important factor that severely affects access to quality health care services. In resource-scarce countries like India, where 27% of the population lies below poverty line, cost becomes a very important issue while accessing quality.

In addition to general health services provided by Ministry of Health and Family Welfare (MOHFW), specific health and nutritional needs of women are provided through the Integrated Child Development Services (ICDS) Programme under the Ministry of Human

Resources Development and newly formed Ministry of Women and Child Development, that was only a department under the MOHFW till 2005.

Under the provision of the Constitution of India, Public health is primarily a state subject. National health programmes have been designed with flexibility to permit the state public health administration to create their own programmes according to their needs and depending on the epidemiological profile of the population. The implementation of the national health programmes carried out through the state government has decentralized public health machinery. The centre will play a co-ordinating role and provide technical and financial support, wherever it is felt necessary.

Most importantly, the central government is to give top funding priority to programmes promoting women’s health. The National Health policy (1983) sets forth several time bound objectives including reduction of MMR(Maternal Mortality rate), IMR(Infant Mortality rate), due to TB and malaria by 2010, and zero growth of HIV/AIDS by 2007.

**Women and Communicable Diseases¹**

In addition to the poor nutritional status, heavy work burden and maternal and prenatal ill-health, communicable diseases including Malaria, Tuberculosis, Encephalitis, Kala Azar, Dengue, Leprosy, Swine Flu etc. contribute significantly to the heavy burden of disease faced by women. Communicable diseases remain the most common cause of death in India.

A 25 year old woman from Davanagere was married to an auto rickshaw driver. She conceived after four years of marriage and was infected with TB. It was routine to do an HIV test for all pregnant women in the hospital. The test revealed that she was HIV positive. Her husband also underwent the test found negative. This created a tension between both the families and they completely disowned her. They left Davanagere and came to Bangalore for a living. She was two months pregnant and visited a local hospital for a check up which refused to treat her and referred her to some other hospital. By then her husband was also tested positive. Thinking that the child would be orphaned, they

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¹ N.B.Sarojini&others, “Women’s Right to Health”-National Human Rights Commission
Page No. 37 available at [http://nhrc.nic.in/publications.htm](http://nhrc.nic.in/publications.htm) (Last Visited on May 29th, 2010)
decided to terminate the pregnancy. The doctors at the public hospital refused and asked her to go to private clinic who demanded Rs.5,000, which they could not afford. She went through a lot of mental strain as it was too late to terminate the pregnancy. Eventually she had a normal delivery, but lost the child.

The rights of the disadvantaged people are further compromised if their HIV positive status is disclosed. People living with HIV are stigmatized and isolated from the mainstream society. They are very often denied admissions into hospitals, schools and lose jobs on discovery of their positive status.

**The Bhopal Gas Tragedy – A Sustained Campaign**

The Bhopal disaster (December 3rd, 1984) was caused by the accidental release of 40 tonnes of Methyl Isocyanate (MIC), a dangerous and toxic gas, from a pesticide plant of the Union Carbide India Ltd. The factory was located in the heart of Bhopal and the gas leak ended up killing almost 20,000 people. According to government estimates, a population of 2,50,000 was instantly poisoned by the gas leak. The effects of the contamination are felt and seen even today, after almost two decades.

While certain health consequences were common to both women and men, women additionally suffered from health problems that were specific to them. The gas will continue to affect generations of women. Among women who were pregnant at the time of the disaster, 43% suffered spontaneous abortions. In the years that followed, the spontaneous abortion rate remained four to ten times worse than the national Indian average. Only 50% of pre-adolescent girls, who were exposed to the gas, had normal menstrual cycles. It is now coming to light that even girls who were exposed in infancy and were in their mother’s wombs are experiencing ‘menstrual chaos’.

An epidemiological study of the Bhopal gas tragedy and did a pregnancy outcome study in Bhopal nine months after exposure to the toxic gas. The study found that women who were pregnant at that time of gas exposure suffered from spontaneous abortions, still births, diminished foetal movements, and menstrual disorders. “not only the soil, but also

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1N.B.Sarojini&others, “Women’s Right to Health”-National Human Rights Commission
Page No. 73 available at [http://nhrc.nic.in/publications.htm](http://nhrc.nic.in/publications.htm) (Last Visited on May 29th, 2010).
the groundwater, vegetables and even breast milk is contaminated to various degrees by heavy metals like nickel, chromium, mercury and lead, Volatile Organic Compounds (VOCs) like dichlorobenzene and halo-organics like dichloromethane and chloroform cause a serious health threat not only to those currently exposed but also to future generations.

**Appropriate Technology for Health –**

There has been rapid development of technology in the last few years but it has eluded the public health system, specifically women’s health. Among the health workers in the village level there is no or poor access to technology who has to deal with common women’s health problem on a daily basis.

Similarly Article 21 of the Constitution of India guarantees the Right to Life of every citizen, and imposes the duty to protect this right upon the state. The Supreme Court of India has previously stated that the right to life includes the right to live with dignity and all that goes along with it, including the right to food. For example, in response to the writ petition on the ‘Right to Food’ by the People’s Union for Civil Liberties (PUCL), Rajasthan, in 2001, the Supreme Court judged that the state governments are indeed violating Article 21 of the Constitution of India. The Court’s judgment in its very essence recognizes the justifiability of the Right to Food, and the protection of this right under the Constitution. The Supreme Court affirmed that where people are unable to feed themselves adequately, governments have an obligation to provide for them, ensuring at the very least that they are not exposed to malnourishment, starvation and other related problems.

**The Directive Principles of State Policy (DPSP)**

As mentioned earlier, the reference to Right to Health in the Indian Constitution is contained in Article 47, which is consigned to the Directive Principles of State Policy (DPSP) section. With regard to health and health care, Article 47 states that it is the Duty of the State to raise the level of nutrition and the standard of living and to improve public health.

In 1973, the Supreme Court of India made a landmark judgment that is pertinent to realization of the Right to Health in India. In the case Keshavananda Bharati vs. the State of Kerala, also popularly referred to as the Fundamental Rights Case, the Court
recognized that the directive principles should enjoy the same status as ‘traditional’
fundamental rights.

**Expedite, Awareness of Health Care in perspective to GM Foods**

In the present day scenario, Women have to take care of health issues and to be more responsive towards the food, food products, edible products, vegetables and fruits. The reason behind that is now a days due to advent of Genetically Modified Foods into the market. It may be in the form of ingredients also. For example in US in certain Chocolates, the ingredients may be Genetically Modified Corn, Genetically Modified Soya bean etc.

**What is this Genetically-modified food?**

The term GM foods or GMOs (genetically-modified organisms) is most commonly used to refer to crop plants created for human or animal consumption using the latest molecular biology techniques. These plants have been modified in the laboratory to enhance desired traits such as increased resistance to herbicides or improved nutritional content. The enhancement of desired traits has traditionally been undertaken through breeding, but conventional plant breeding methods can be very time consuming and are often not very accurate. Genetic engineering, on the other hand, can create plants with the exact desired trait very rapidly and with great accuracy. For example, plant geneticists can isolate a gene responsible for drought tolerance and insert that gene into a different plant. The new genetically-modified plant will gain drought tolerance as well. Not only can genes be transferred from one plant to another, but genes from non-plant organisms also can be used. The best known example of this is the use of B.t. genes in corn and other crops. B.t., or Bacillus thuringiensis, is a naturally occurring bacterium that produces crystal proteins that are lethal to insect larvae. B.t. crystal protein genes have been transferred into corn, enabling the corn to produce its own pesticides against insects such as the European corn borer.

**What is Genetic Modification?**

Genetic modification involves altering an organism's DNA. This can be done by altering an existing section of DNA, or by adding a new gene altogether. A gene is a code that

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governs how we appear and what characteristics we have. Like animals, plants have genes too. Genes decide the colour of flowers, and how tall a plant can grow. Like people, the characteristics of a plant will be transferred to its children the plant seeds, which grow into new plants.

When a scientist genetically modifies a plant, they insert a foreign gene in the plant's own genes. This might be a gene from a bacterium resistant to pesticide, for example. The result is that the plant receives the characteristics held within the genetic code. Consequently, the genetically modified plant also becomes able to withstand pesticides.

In October, 2009, Genetic Engineering Approval Committee (GEAC) has approved genetically modified or Bt brinjal for human consumption despite protests that adequate tests have not been carried out to ensure it is safe for human consumption. The Genetically Engineering Approval Committee (GEAC) has given approval for the environmental release of the Bt brinjal, Environment Minister Mr.Jairam Ramesh told after studying the panel's report before deciding whether it should be given clearance or not. For that purpose Ministry of Environment and Forests, decided to conduct the public hearing on Bt.Brinjal on the dates of 13th, 16th, 19th, 22nd, 25th, 27th and 30th of January at Kolkata, Bhubaneshwar, Ahmedabad, Hyderabad, Bangalore, Nagpur and Chandigarh.

This public hearing will create awareness among the general public and will improve the acceptability of GM foods and the Bt brinjal. The Researcher also delivered his opinion on Bt Brinjal to Hon’ble Minister of Environment and Forests Jairam Ramesh in National Public Consultations held at Hyderabad on January 31st 2010. The presentation video of Researcher consisting of one minute duration can be available on ministry of environment and forests website.

There was a letter dated January 10th, 2010 to the Mr. Jairam Ramesh, Minister of Environment and Forests from the Professor David S. Williams, University of California, Los Angeles commented on the report of Expert Committee (EC-II) on Bt. Brinjal that with its current lack of molecular characterization, being grown and consumed by

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1 The National Public Consultation held at Kolkatta, Bhubaneshwar, Ahmedabad, Hyderabad, Bangalore, Nagpur and Chandigarh. In Hyderabad held on January 31st, 2010. Under the yellow placard (Research Scholar, Scientists, Faculty) the Author also participated and delivered the opinion.
humans, especially on such a large scale as that proposed leaving public policy up to people. Later Minister of Environment and Forests imposed a moratorium on Bt Brinjal in February, 2010.

**GM food can cause cancer**

It is also not clear how the GEAC overlooked the fact that Bt brinjal has a protein that induces resistance to antibiotics. There was no proper study on hormonal impacts of Bt brinjal—Bt toxin found in it could lead to reproductive health problems.

There is a projection that GM plants turned food reduce the need for pesticides, but it is a false projection. Bt plants, in fact, are designed to produce toxins to repel pests. According to reports or sources Bt brinjal produces a very high quantity of 16-17mg toxin per kg. They affect animals. Unfortunately, tests to ascertain their effect on humans have not been conducted.

Toxins in GM plants can cause cancer, hormonal and reproductive problems and disorders of the nervous system. These chronic diseases are exploding all over the world and to our knowledge bacteria or viruses are not causing them. They may be due to chemicals contained in food. So, we definitely do not need food full of synthetic chemicals.

**Pregnant mothers eating GM foods may endanger offspring**

1. Embryo development can be adversely affected by tiny amounts of substances in the mother’s diet.

2. A pregnant mother’s diet may even alter gene expression in children and be passed on to future generations.

3. GM crops may contain substances that impact normal fetal development, but have never been adequately tested for these effects.

**Putting things in Perspective**

Inspite of seeing so many man made and natural calamities, we have been heralding into one more man made disaster. A disaster which may prove far more destructive that anything we have never seen so far. Nature allows you to cross a wheat plant with a wheat plant, nature allows you to cross a maize plant with a maize plant, tomato plant

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1 Jeffrey M. Smith, (First Indian edition 2009) “Genetic Roulette”: Other India Press in association with South Against Genetic Engineering (SAGE) and Deccan Development Society (DDS), Hyderabad.
with a tomato plant, or a pig with a pig, horse with a horse, you know like that, it does not allow you to cross a inter species crosses. What Genetic Engineering is doing is, you can actually cross, in that sense, you can actually cross or being a character, for let's say pig into a human beings or from a human being into one plant. People should know that when you mix this genes this way, then you are coating disaster, because of the disease comes with it so why you should want to use it.

**GM foods – Vegetable oils:**

GMO (genetically modified organisms) are those whose genes are manipulated to make a bigger and a better product. GM foods are those in which GMO are used. Due to the recent advancement in the technology, the soy beans are genetically modified for higher protein content and the soy beans grown in the Argentina and Brazil are mostly GM soy beans.

– Most of the Soy oil imported into India is crushed from GM soy beans.
– If the government’s move were to be implemented, most of the edible oils sold in retail and the foods in which the imported GM oil is used are to be labeled.

The ‘Right to Health’ has yet to be acknowledged full fledged as a fundamental right in India. Women’s groups, health and human rights activists in the country have been campaigning for several years for Health to be recognized as a constitutional guarantee. In this ongoing struggle, women along with these groups and activists have played a critical role in the process of formulating their health rights – in deciding what their rights should be, the content of these rights and the processes by which these rights can be claimed. These processes have also witnessed application of existing international conventions to hold the State accountable for violating these rights.

The understanding and scope of women’s Right to Health is constantly evolving as women participate more actively in these processes, causing changes in attitudes towards women and their health, bringing about change in the way laws are formulated and interpreted. Combined efforts are required now, more than ever, to demand and ensure the recognition of Right to Health as a fundamental right.

Social restrictions on women's mobility contribute to lesser healthcare for women and children. For example, 90 per cent of married women in Uttar Pradesh and Jammu and
Kashmir and about 80 per cent in Bihar, Madhya Pradesh, Rajasthan, Haryana, West Bengal, Andhra Pradesh and Assam need permission to visit even friends and relatives. Women's health tends to be viewed narrowly as reproductive health, whereas many factors need to be considered. For instance, communicable diseases are more of a threat to women than pregnancy. Tuberculosis and not pregnancy is the leading cause of death of women in the reproductive age group, followed by burns and suicides.

**WOMEN CONSUMERS**

Every woman member of the family is either a consumer of goods or services or a consumer of both. Unfortunately, because of lack cohesiveness and lack of effective organizations to voice their concerns, a women consumer in India has remained a faceless, voiceless, submissive and meek person, accepting whatever sub-standard goods or services being offered. “Consumer” means and includes person and families purchasing and receiving food in order to meet their personal needs\(^1\). The women consumer aggrieved by the act of unfair trade practices, supply of defective goods and most importantly in the area of services being provided by various sectors like banking, insurance, medical, housing, transport, telecom, tourism and travel, electricity, etc. I suggest the Ministry of Women both in centre and states has to establish separate panel or board to empower or educate the women consumer on the tremendous impact in protecting and promoting their rights.

**Challenges**

The holistic and universal development of women must concentrate on the aspects of literacy, education, health and nutrition, water and sanitation, skills, technology, credit, marketing, asset base, political participation, property rights. Technology must be proactive and facilitate women. Technological development in education, health and nutrition, water and sanitation and skills development must reach all women particularly women at grass roots.

The Government has to propose to launch year long activities to bring about a change in the environment which will be conducive to develop self-confidence and assertiveness among women and children, especially in Health aspects.

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\(^1\) *Section 2(f) of the Food Safety and Standards Act, 2006.*
The Labeling of food must be made mandatory in view of genetically modified food. It should be the consumer choice to buy food on their own choice.

The Government has to enhance and improve the public investments, expenditures, accessibility in health care.

**Recommendations to State Government/State Health Ministries**

- The adoption of an integrated human resource development plan to ensure adequate availability of health, human power at all levels.
- A Health Care system which is responsive to the people’s needs and whose control is vested in peoples hands.
- Promotion of transparency and decentralization in the decision-making process, related to Health Care, at all levels as well as adherence to the principle of right to information. Changes in health policies to be made only after mandatory wider scientific public debate.

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