EDITORIAL

Some Thoughts On Republic Day, 26 January 1987

TODAY, 37 years after the establishment of the Republic, a child born in India can expect to live an average of only 57 years. Too many people, especially women and children, die very young, mainly of preventible and easily curable illnesses. Women in the reproductive age group and children are more liable to succumb, primarily due to a combination of undernourishment and infections.

The surviving population is prey to a host of sicknesses such as tuberculosis, malaria, goitre, and chronic diarrhoea, which seriously damage the quality of their life. A majority of Indian women are anaemic and at great risk during childbirth. India has one of the highest rates of death during childbirth in the world. A large number of children suffer from physical and mental retardation and handi-caps of various kinds as the effect of undernourishment and disease.

At independence, it is true, things were even worse than they are today. Since then, there has been much improvement. But, when one looks at certain other poor countries, one finds that people there do not die so frequently from easily preventible illnesses. In these countries, successful efforts to save the lives of women and children have often included subsidised food distribution, clean drinking water, basic improvements insanitation, basic health care, and imunisation against infections. Primary edcation for women is also closely associated with rapid lowering of the death rate in these countries.

Just because India is a poor country, it is not inevitable that so many millions of our people should die every year of hunger and disease. Other poor countries where such deaths have been prevented have economies as different as those of China and Sri Lanka. The high rates of sickness and death in India today are unnecessary and can be avoided at relatively low cost, and even without slowing down

The parade goes on

—India's expenditure on welfare is low and declining as a percentage of total government expenditure. Expenditure on warfare is the fastest growing part of the budget. In 1983 the central government allocated 2.4 percent of its expenditure to health, 1.9 percent to education and about 20 percent to warfare. The proportion spent on warfare has increased rapidly since then.

investment in industry and agriculture.

A key requirement is the development of the political and social will to reduce needless suffering and death. Despite all the government rhetoric about human resources development, we have not yet even developed the will to save the lives of the millions of men, women and children in our country who are dying needlessly every year.

Wasteful ?

Many people think that providing a basic minimum for survival such as subsidised food for the hungry poor is a wasteful expenditure. They argue that government should only invest in so-called productive, income generating schemes. They believe this is the only road to overall economic growth. They think that only after the eradication of poverty will death and illness rates go down more substantially.

Some government bureaucrats shower us with statistics in the newspapers, trying to give the impression that the government is not neglecting the people's survival needs. However, they often seem conveniently to forget that even the small amount of money being spent on health and education is mostly misspent.

For example, they gloss over the fact that more money is spent on higher education than on primary education, that is, very little money is spent to provide education for each poor child while much more money is spent on far fewer and richer young people. Girls, especially those from poor families, get even less benefit from money the government spends on education, since most girls who go to school at all drop out during the early years of primary school.

More money is spent on expensive training for doctors than on developing a network of rural health workers, nurses and midwives. More money is spent on highly equipped topheavy health institutes for the favoured few in the urban areas than ou public health measures such as immunising people against killer diseases like tetanus.

Simple measures that could save lives

Four year old washing utensils

are criminally neglected. Take the case of goitre, a disease to which women are more vulnerable, and which causes, among other things, mental retardation and physical deformity. It is caused by iodine deficiency and can be prevented by iodising salt. This would cost only a total of 50 to 90 paise per person per year in goitre affected areas. Although this is well known, no effective action has been taken to see that salt is iodised.

Most of the meagre resources the government spends on health, education and welfare never reach those for whom they are meant, but are spent on propping up a wasteful bureaucracy. Most health centres and schools in rural areas do not serve those whom they are meant to serve. They serve the interests of the administrators and the staff rather than serving the people.

People are too oppressed and demoralised to demand service as a right. The most vulnerable sections of the population— women and children — are the most neglected because they are the most powerless. The distant and all powerful government appoints administrators and workers in village health centres and schools. These people are accountable only to their superiors and not to the local community. They will suffer only if they cross their bosses or some influential politician. They can safely afford to neglect the villagers and be callous to their needs.

Measles or its complications kill 200,000 to 300,000 children each year in India. A single dose of vaccine costs less than Rs 2.

The presence of the government machinery in the village creates the illusion that government is a provider for and a protector of the poor. In fact, this machinery primarily serves the interests of those who run it. It ends up acting as a major obstacle in the way of people's organising for their own welfare.

Female Autonomy

It is well known that a high rate of female primary education is highly related to the health level of a community. A recent study, "Routes to low mortality in poor countries" by John C. Caldwell, in *Population and Development Review,* June 1986, brings together important data to show that women's autonomy may be an even more crucial factor than education in helping reduce death rates and improve the health of a population.

Caldwell makes an important distinction between education and autonomy. Both are essential. However, the first is not equal to the second. Nor is autonomy the same as respect. Many communities which give women, a certain kind of honour do not allow them autonomy.

A more autonomous woman may be defined as one who has greater say in decisions that affect her life such as her education, her employment, whether to marry or not and if so, at what age, whether to have children or not and if so how many, In a society where women have more autonomy, it will be reflected in their being able to move more freely outside the house, without being viewed with suspicion and hostility, and consequently having greater access to information and a wider range of alternatives.

When women in any social group are not secluded, girls are more likely to be sent to school and to continue schooling even after puberty. They are also likely to marry at a later age. A literate woman who marries later is less vulnerable to abuse and discrimination than an illiterate woman married young, and is more likely to be able to decide the number of children she wants. In such a culture, women are also likely to perceive their daughters as of some worth, and to treat them more equally to sons, in matters of food, education and medical treatment.

In Sri Lanka 87 percent of births are attended by trained personnel while in India 33 percent are said to be so attended.

In a society where a woman does not have to seek the permission or escort o f male members of the family in order to go to a health centre for herself or her child, chances are that she will make fuller use of the service. Since mothers are generally in greater long term proximity to children than are fathers, a mother's level of information and her ability to use health services is vital for the health of the child.

Therefore, when a woman's position in the family and society is better, her child's situation is also likely to improve. For example, when society does not disapprove of a woman moving about on her own, woman are not only freer to seek health care but also can be more assertive in demanding attention from health workers and in taking the necessary steps to follow their instructions. Such women can play a vitally important role in monitoring health agencies and pressuring them to perform efficiently. It is absolutely vital that women be able to perceive it as their due to receive competent attention and care from the services, and be able to demand this care as a right.

A good example of such a society is Sri Lanka. It does not have a tradition of secluding women nor of obsessive concern with women's chastity as a repository of men's honour. Patrilocality is not the only rule. A 1978 survey found as many young married couples living with the wife's as with the husband's parents.

In 1947, free education legislation, forbidding any school to charge fees, was enacted in Sri Lanka . Later, a massive nutrition programme for the poor was launched. Its aim was to prevent anyone getting less than a certain minimum amount of food. Today, Sri Lanka has a high

1985 annual number of deaths per 1000 persons	12	6
1985 ranking among 130 countries for annual number of deaths of children under 5 years per 1000	40	82
1985 annual number of deaths of infants 0-12 months, per 1000 live births	105	36
1985 average life expectancy at birth	57	69
1984 annual per capita income (USA)	260	360
1983 daily per capita calorie supply as percent of requirements if food production is divided by population	96	106
1985 percentage of literate males to all males	57	91
1985 percentage of literate females to all females	29	83
1984 percentage of births attended by trained personnel	33	87
1980-84 percentage of grade I students completing primary school	38	91

From *The State of the World's Children, 1987,* UNICEF, Division of Information and Public Affairs, UNICEF House 3 UN Plaza, NY, USA

Table II Mortality and Welfare Rates in Kerala, Punjab and UP

1980 death rate per 1000 persons*	6.9	9.2	16.4
1980 annual death rate per 1000 infants aged 0.12 months*	40	89	159
1976-78 percentage of infant deaths to total deaths*	16.9	30.4	35.1
1981 Sex ratio (females per 1000 males)*	1,034	886	886
1981 Female literacy (percentage of literate females to all females)* rural	64	34	14
1983-84 percentage of rural population below the poverty line**	26.06	10.87	45.48

* Data from UNICEF *An Analysis of the Situation of Children in India,* United Nations Children's Fund, Regional Office for South Central Asia, New Delhi, 1984 (pp.27, 24, 32, 66 respectively)

** Data from V.M. Rao and R.S. Deshpande, "Agricultural Growth in India: A Review of Experiences and Prospects:, *Economic and PoliticalWeekly,* 21 (38-39), Sep, 20-27, 1986, p.A-105

general literacy rate. Its female literacy rate is about as high as that for males. The expectation of life at birth is 69 years, very close to the rate in many developed countries. There has been a remarkable decline in the numbers of infant, child and maternal deaths.

The Case Of Kerala

The best example in India of this pattern is Kerala. A small, densely populated and economically poor state, it has nevertheless the most literate population in India and the highest female literacy rate. Of all Indian states, Kerala is the one where children, especially girls, are least likely to be withdrawn from school and put to work. The age of marriage for women is high.

In 1983-34, 26.06 percent of Kerala's rural population lived below the poverty line. This is more than double the figure for Punjab. Yet, Kerala has the lowest death rates of any state in India. Far fewer babies die in Kerala and the rates have been steadily declining over the last two decades. A child born in Kerala today has a far higher life expectancy (66 years in 1982) than any other state in India.

How has all this been achieved? Though there are some special historical circumstances, the main factors are as follows. The health and educational services its people developed are more responsive to people's needs and are within easier reach of each community. Primary education gets a budgetary allocation comparable to the expenditure on higher education. The immunisation programmes are more effectively implemented.

One of the most important contributory factors is the position of women. Kerala has traditionally had less seclusion of women than most other parts of the country, and this is true of all religious communities.

Certain influential communities practised a matrilineal system of inheritance which is relatively more egalitarian than the patrilineal system. Daughters are not consi-dered a burden ; dowry was not widely practised ; it is not considered shameful for a woman to earn nor was there an obsessive concern with women's chastity as the hallmark of family honour. Unfortunately, many of these family and marriage patterns are now beginning to be replaced by more antiwomen, all-India patterns.

Women's death rate in Kerala is lower than min's in every age group. Biologically, if social factors do not interfere, survival rates for men and women should not go against women. In developed countries, and in many poor countries like Sri Lanka, women have higher survival rates than men. But in India, overall, women's death rates are much higher than men's. This has resulted in there being over 20 million fewer females than males in India's population. However, there are more females than males in Kerala.

Women in Kerala move about more

freely than in most other parts of India. This is visible in the fact that many more women from Kerala enter nursing than those from any other state. They are also more likely independently to take various jobs in other parts of the country and abroad.

The willingness of Kerala families to let their daughters become nurses and health workers contributes to the development of an efficient health service in rural areas. In many other parts of India, one cause of the miserable inadequacy of the rural health ser-vice is the lack of literate and trained female health workers to look after people's needs, especially those of women and children. In communities where women have less autonomy, nursing is viewed as disreputable, because it involves women living away from their families, working uncertain hours and coming in contact with male doctors and patients.

India is one of the few countries in the world which has more doctors than trained nurses. But most deaths in rural areas result from infections that could easily be prevented by the services of health workers well trained in primary health care and backed up by a medical team. They do not need to go through the lengthy, partially irrelevant and expensive training that a doctor gets. Such training often makes a doctor less fit for the preventive helping and educational work that is so essential for most parts of our country.

Women in Kerala make more and better use of the available health facilities for themselves and their families. They react more quickly to sickness. Since most child deaths in India are caused by preventible and curable waterborne infections, and by dehydration following diarrhoea, even a poor women can often save her child's life, if she gets the child immunised against infection, knows something about how infections arise, seeks timely medical assistance, and follows medical advice intelligently. Costly and hard to get drugs are rarely needed.

The case of Kerala clearly demonstrates that we need not wait to save lives until overall economic prosperity is achieved. Relatively inexpensive measures can be taken to prevent needless deaths. Closer study of the history, society and polity of Kerala could yield important lessons for the rest of India.

Prosperity Alone Not The Answer

Significantly, a much more prosperous state, Punjab, which has a better fed population, lags behind Kerala in many areas of health, education and welfare. Even though the people overall are better fed than in Kerala and fewer live below the poverty line, the death rates are higher, because communities, are not yet educated and aware enough to demand and implemeni measures for the prevention and cure of chronic and fatal ailments.

The devaluation of women in Punjab results in their being unwanted and neglected in many ways. More girls and women die in every age group than boys and men. Punjab has many more men than women in its population. Many more

infants and children die than in Kerala, largely because they are not sufficiently protected against infection.

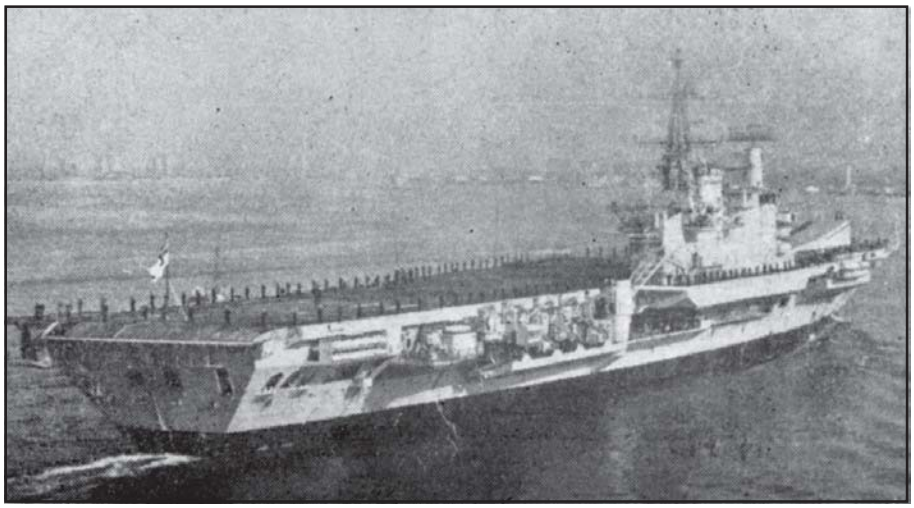
Punjab being as relatively prosperous as it is,there is no obvious reason why the death rates should be higher than in Kerala. Clearly, greater economic prosperity alone is not enough to ensure better survival capacity to its people. Certain social factors also play an important role. In Punjab's more hierarchical, more heavily patriarchal and patrilocal society, women have a more dependent status.

A woman in rural Punjab has much less autonomy and less control over her own life than in Kerala, and is less able to assert her to education and health care. Thus, despite the more prosperous economy, people are not able to take maximum advantage of existing facilities or to make these facilities responsive to their needs.

The state of UP provides a typical example of how poverty and social subjugation, when they coincide, result in greater suffering for all, especially for women and children. The death rates are startlingly high; literacy rate in gerneral, and especially for women, abysmally low. The society is caught in a rut from which it will be hard to emerge unless a deliberate effort is made to give control over their own lives back, to people, and to give women greater say in the functioning of their family and community, as well as in their own lives.

Misplaced Expenditure

The Indian navy has just bought a second aircraft carrier Virat, from the British navy, and is thinking of manufacturing a third one. It aleady owns the Vikrant. The aircraft carrier is by far the single most expensive weapon system in the world. One US carrier costs about Rs 5,000 crore. As it presents a very vulnerable target, it has to be guarded by a number of escort vessels, which cost about Rs 18,000 crore more. The operating costs of such a carrier alone is Rs 50 lakh a day. Experts believe that in any



The Virat —formerly HMS Hermes

major war, an aircraft carrier cannot expect to last more than two days, as it can be destroyed at will j by any small nation at minimal cost, by the deployment of cheap and accurate long range missiles. For these reasons, China, Japan, Australia and Canada have eliminated the aircraft carrier altogether from their navies, while the superpowers are cutting down their carrier fleets. Why are we buying aircraft carriers ?

(Estimates from Brig. N.B. Grant (Retd.) . *Indian Express*, December 52, 1986, p. 8)

Women's Involvement

Since women are the most discriminated against in matters of health and education, their involvement is vital. Groups helping rural communities organise need to lay special emphasis on issues of women's autonomy in the family and community. It is there that women's freedoms—of decision making, of alliance, of mobility— are initially and effectively curbed. It is there that the devaluation of women is rooted.

As long as women are at the receiving end of neglect and abuse in the family and community, it is unlikely that health and educational agencies will be greatly concerned about their lives and well being. After all, the persons running these agencies are also products of the same society and have the same biases against women that are current in that society.

We must avoid falling into the trap of looking at women as means to an end. Government propaganda often lays emphasis on women's health solely as a way of ensuring a healthy new generation to build the nation. This misplaced emphasis solely on the mother rather than the woman as a person in her own right with many concerns, is not only morally wrong but also generates many problems.

Every year, 1,500,000 children in India under 5 die of diarrhoea.
Every year, 280,000 children inIndia die of neonatal tetanus.

Community Control

At present, the staff of rural health centres and schools are, in the main, brutally indifferent to people's needs, except when pressured by influential persons who, they fear, can affect their

positions if offended. The solution to this problem is to make as many people as possible influential, not in the sense of having connections with higher ups, but in the sense of having an important say in the quality and character of local services.

Local health workers and teachers should be the employees of the local community. They will then be accountable to those whom they serve. Committees elected by the community should evaluate their services. Women should constitute at least 50 percent of the members of the board. This is an essential part of real decentralisation of power.

Control over local services must not be at the central or even the state level. It must be at the district and especially at the village level. Only then will it be possible for women to have an effective say in decision making at the level where it most affects their own and their children's lives.

This will require getting top heavy government machinery to withdraw and make space for local self government.

The community, with the full participation of women, should decide the priorities in primary health and education, and should have control over the resources. They should be able to allocate the resources according to their own priorities.

We cannot expect welfare services to respond to people's needs if people remain passive recipients. Only an active community which asserts its rights can actually get the goods delivered. To achieve this, it is necessary to work simultaneously on different fronts. Local social, cultural and political factors must be taken into account, not only larger political and economic influences and considerations as has so far been the case.

Minimum Programme

Clearly, in India, there is a failure to deliver health services to the people. Even when immunisation programmes exist, there is not enough outreach. The case of Sri Lanka shows how, despite poverty, it is possible to reach basic health services to people, given the political and social will to do so.

Neonatal care in the rural areas—of vital importance

Some programmes that government often talks about but does not implement adequately, and to demand which women could organise, are :

1. Clean and adequate drinking water supplies through taps within easy reach of every family.
2. A well run primary school within easy reach of every child.
3. A basic food needs programme for all, including special food supplements to malnourished pregnant and lactating women, and school meals for poor children.
4. Guaranteed year round rural employment programmes accessible to all unemployed and underemployed poor persons. Employment on demand or unemployment allowance to every woman.
5. Financial incentives to parents of girls to see that they go to school.
6. Food for study programmes to impart literacy and numeracy to women and

girls who are not in school.

7. Immunisation of every person against preventible infections like tetanus and polio
8. Effectively functioning primary health care centres with at least one woman health worker, with-in easy walking distance of every family. This centre to be responsible to the people of the community, especially women.

What We Need

Today, what we need is not an abstract "national unity", but people's unity to reorganise society at the community level, in a way that control over local resources and services comes back into the community's control. Women are especially important in this reorganisation.

What we need is not a powerful government at the top, which arbitrarily takes decisions affecting people's life and death, but stronger local self government controlled by and serving people's needs.

There is no reason why an average person in India should not expect to live to at least 65 years of age. There is no reason for people in India to be resigned to so many of their children dying or that childbirth should be such a major hazard for women.

There are over 3,200,000 leprosy cases, approximately 2,00,000 malaria cases, and over 500,000 tuberculosis deaths annually.

These millions of deaths and chronic sicknesses are unnecessary and are not an inevitable outcome of India's poverty. We do not have to wait until India becomes an affluent country before we can prevent them. The ways to prevent them are known and have been demonstrated over and over again in countries as poor as India. Kerala's example shows how so many deaths and illnesses can be prevented.

On Republic Day, we should rededicate ourselves to the constitutional right of people to life, not only in the sense of their right not to be killed outright, but also in the sense of their right to live the dignified life that is possible in India today.

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