Chapter 1

Introduction
A healthy mother is expected to give birth to a healthy and normal child, further more, children born to malnourished mothers remain, at a high risk of developing malnutrition, thus by improving health status of women a corresponding improvement in the health of new born can well be expected.

Among various nutritional disorders affecting women of child bearing ages all over the world, anaemia holds a top position. It is known to cause widespread ill effects on the pregnancy and its outcome.

Diet and nutrition are important factors in the promotion and maintenance of good health throughout the life cycle. A normal balanced diet must include daily foods from the various food groups in sufficient amounts to meet the needs of an individual. Health and nutritional status of individuals depends on the food she eats. The components of the diet must be chosen judiciously to provide all the nutrient needed in adequate amounts and proportions. Food stuffs selected from each group should take into account the income, sociocultural factors, availability and nutritional requirement, selection of foods from the different food group also results in variety in the diet,
which not only ensures nutritional adequacy but also increases food acceptability. It was reported by Zive et al., (1996) that deficient intake of essential nutrient such as calcium, iron, magnesium, zinc, folate, vitamin A, Vitamins B₆, Vitamin C were found more in large proportion of young women than young men. A faulty diet can certainly be a source of stress and this leads to the formation of poor dietary habits. Women with deficiencies of folic acid and other vitamins are an increased risk of cardiovascular diseases.

Amongst various nutritional disorders affecting women of child bearing ages all over the world, anemia holds a top position. It is known to cause widespread ill effect on the pregnancy and its outcome.

All the iron needed for the biological function comes from diet. Although cereal pulses based diets are regarded as good sources of iron, the non-home iron present is relatively poorly absorbed.

Nature and magnitude of Anemia in rural women W.H.O. sponsored studies (WHO, 1968) indicated that prevalence of anemia in rural women in different parts of world, ranges from 21% to 80% the highest being in India. These studies further indicate that prevalence rate of anemia not only differs between countries but also between region within a country.
Haemoglobin estimation is considered as a most practical method of diagnosis. It is most effective and could be performed by well trained technician. The cut off level of haemoglobin to anaemia is not standardized all over the world. In India some consider cut off level of haemoglobin as 8 g and other consider 10 g as cut off point. The guidelines of WHO consider any haemoglobin less than 11 g/dl in pregnancy as anaemia. We feel that WHO standard definition should be accepted all over the world. This would help in comparison of data from one centre to another. Ideally it is important to know total circulating haemoglobin mass. It gives exact idea about haemoglobin status of the person. But estimation of total circulating haemoglobin is not very simple. It requires more expertise and costly equipment. Rapid loss of blood as in haemorrhage would reduce total haemoglobin mass but haemoglobin concentration would not be affected immediately. In chronic nutritional anaemia, haemoglobin concentration underestimates the severity of anaemia because in chronic nutritional anaemia, there is reduction in red cell volume while plasma volume remains constant. Therefore, in spite of these limitations, estimation of haemoglobin-concentration per 100 ml of blood remains practical method to diagnose anaemia.

There are several methods for haemoglobin estimation. The Tallquist's method of haemoglobin estimation has simplicity and easy...
applicability. However, it does not provide accurate, replicable estimate of haemoglobin. The copper sulphate method though simple, has many drawbacks and is not reliable. Sahili’s method is reliable and accurate when done by experts. However, it has not proved reliable when done by paramedicals and half-trained technicians. At present cyanmeth-haemoglobin method appears to be most reliable. Unfortunately, this method is not very popular even in teaching institutions. Sahli’s method is used largely at most centres.

Iron deficiency anemia is one of the most common nutritional disorders world-wide, especially in India and other developing countries, young children and women in the reproductive age group are most venerable to iron deficiency anaemia.

Surveys in different parts of the country reveals that 87% of pregnant women suffers from anaemia and about 10% have severe anaemia (H < 80 g/l). Variation in the prevalence rates of anaemia are seen within the country with the lowest prevalence of 33% being reported from Andhara Pradesh to highest of 98% in Rajasthan. Severe anaemia is an important risk factor in pregnancy, report from India indicate that 16% of all maternal deaths are attributable to anaemia.
Anaemia is one of the most widespread nutritional deficiency disease. It affected all age groups and both sexes in most states of India. Profoundly affect groups are adolescent girls (74% to 98%). Pregnant women (82% to 98%) and women in childbearing age (74% to 99%).

Sood (1967) compared to prevalence of anaemia in three groups of women viz. (a) 504 pregnant women from co-operation, maternal and child welfare centre New Delhi, (c) 106 women of a rural area of Delhi. It was observed that in these three groups the prevalence of anaemia varied significantly, being 27.3, 43.0 and 47.0% in a, b, & c groups respectively.

Nutritional Anaemia is a world wide problem with the highest prevalence in developing countries it is found especially among women of child bearing age, young children during pregnancy and lactation. It is estimated to affect nearly two third of pregnant and one half of non-pregnant women in developing countries. The population of developed countries are not by any means completely free of anaemia and a significant percentage of women of child bearing age (estimated between 4 & 12 percent) suffers from anaemia.

In India anaemia is a major nutritional problem and in many other developing countries. In addition, many subjects have iron
deficiency without anaemia. The incidence of anaemia is highest among women and young children varying between 60% to 70%. Recent survey indicate that in rural India anaemia is much more widespread than higher to be believed even among man.

In India IMR (infant mortality rate) is 61 per live birth. In India maternal mortality rate per 1000 live birth is current level 407. In Uttar Pradesh there are 707 MMR (maternal mortality rate) per 100,000 live births.

The major causes of MMR during the year 1998 were anaemia (19%) in India.

Various surveys have been conducted in Bundelkhand region and it has been found that 70% of the women in the rural area of Bundelkhand suffers from anaemia.

In order to prevent nutritional anaemia among mothers and children (1-12 year) the Govt. Of India sponsored a National Nutritional Anaemia Prophylaxis programme during the forth five year plan. The programme is based on daily supplementation with iron and folic tablet to prevent mild and moderate cases of anaemia the beneficiaries are ‘at risk’ group viz. pregnant women lactating mothers and children upto 12 years.
MCH (mother and child health) is not a new speciality. It is a method of delivering health care to special group in the population which is especially vulnerable to disease, disability or death. These groups (i.e., children under the age of 5 years and women in the reproductive age group (15-44 years) comprise about 31.6 per cent of the total population in India (75).

The MCH services encompaes the curative, preventive and social aspects of obstetrics, paediatrics, family welfare, nutrition, child development and health education. The specific objectives of MCH are:

1. Reduction of morbidity and mortality rates for mothers and children

2. Promotion of reproductive health, and

3. Promotion of the physical and psychological development of the child within the family.

Though concerned with child development and the health education of parents and children, the ultimate objective of MCH services is life-long health.
The components of MCH include the following sub-areas

a. Maternal health

b. Family planning

c. Child health

d. School health

e. Handicapped children

f. Care of the children in special settings such as day care centres.

The content of MCH care will vary according to the demographic, social, and economic patterns. Factors such as urbanization, rural migration, changing patterns of women's work and status have far-reaching effects on childbearing and child-rearing. It is now generally accepted that the MCH services should always be flexible and based on, and adapted to the local needs and resources of the community it serves; they should be moulded to the local traditions, cultures, and other environmental characteristics and cannot be modelled on patterns copied from other countries. Health care, social legislation, and social support measures also will have to be adapted to these changing needs and problems of the community.
MCH care is now conceived of as all activities which promote health and prevent or solve health problems of mother and children, irrespective of whether they are curative, diagnostic, preventive or rehabilitative, and whether they are carried out in health centres or in the home by primary health care workers, traditional dais, or highly trained specialists.

Maternal and child care was traditionally designed and provided in the form of vertical programmes with standard technical content based on models from a few developed countries. Applied in different socio-economic situations, such vertical programmes have been unable to provide more than minimum coverage because of their cost, and they have scarcely been of a kind to solve the priority problems of the majority of mothers and children. The emergence of some new concepts is now changing the organization and management of MCH care in increasing number of countries.

Conventional MCH services tended to be fragmented into antenatal care, postnatal care, infant care, family planning etc. The various components were dealt with separately by different staff or departments. This approach has changed over the years. The trend now is towards an "integrated" approach. This integration is based on the fact that it is inconvenient for the mother to go to one place to receive

Social and psychological factors leading anaemia among rural women in Jhansi District
care for herself, to another for care for her children and yet another for family planning services.

An integrated approach implies that all those involved in maternity care from the obstetrician down to the local dai, must work as a team. Obstetric and paediatric units should be closely linked so that there can be regular contact between obstetricians, paediatricians, community physicians, health and social workers so that services for the care of the mother and the child in the hospital and community be planned and reviewed including teaching and research. This approach will help to promote continuity of care as well as improving efficiency and effectiveness of MCH care.

A new and promising means of improving the coverage and efficiency of MCH care and family planning is the "risk approach". This is a managerial tool for factor use of scarce resources. It is based on the early detection of mothers and children with high risk factors. All mothers and children with high risk factors are given additional and more skilled care including hospitalization, while at the same time essential care is provided for the rest of the mothers and children so that every one gets care appropriate to their need.

It is also possible to assess the "degrees" of risk of each factor, by scoring according to their (a) magnitude - i.e., extent and severity;

Social and psychological factors leading anaemia among rural women in Jhansi District
(b) testability - responsiveness to treatment and control; (c) cost effect - in terms of alleviating woman suffering; and (d) community attitude - social concern. Such an approach when applied on a community-wide basis enables the determination of priority activities, within the MCH programme based on the "degrees" of risk.

Application of the risk approach to the problems of mothers and children is a departure from past or traditional practices to promote the health of mothers and children.

If one is to identify one strategy that would change. The tide of maternal deaths, it would be female literacy and socio-economic status. Female literacy and maternal mortality are intertwined in an inverse relationship. Improving the former will reduce the latter. Educating women allow them to take better charge of themselves. It improves their economic power and a better social and legal status follows. All these decrease sex-gender biases, the single most important link between sociological and medical contributions to maternal deaths. In countries where women are the 'lesser sex', their persecution starts inutero. Female foetuses are preferentially aborted; if born, girls are considered a liability rather than an asset. They are underfed, overworked (with no economic reward) and take second place to the
boys for education and health care. They, start their child bearing career early and have many children, only to produce family heirs (boys).

The girls born to these women will suffer a similar plight. Education can liberate such women from this vicious cycle. Improving female literacy and lowering sex-gender biases lead to better health seeking behaviour amongst women, greater contraceptive use and more liberal utilisation of available health resources. The education can be delivered by both formal and informal means. Countries should be encouraged to enrol girls into primary and preferably secondary schools as well. Apart from the usual curriculum, girls should be taught general hygiene, reproductive health and contraception. This formal education will have a multiplier effect in that important messages can be carried home to less literate parents. Equally useful are informal and novel methods of education: Although a major proportion of girls in developing countries have no formal 'western' education, many may have access to religious teaching centres. Opportunities should be seized to involve these religious organizations to help deliver necessary lessons in reproductive health. Much of the teaching can be done by female volunteer teachers; many would find this more acceptable. The media and non-governmental volunteer organizations (NGOs) too can
adopt this social responsibility towards a common goal of improving the fate of lot of women in many developing countries.

Iron fortification, the W.H.O. Experts (49) did not recommended iron fortification strategy for control of anaemia in region where its prevalence is high.

There are other instances such as changing dietary habits control of parasites and nutrition education. These are long term measures application to situation where the prevalence and severity of anaemia are lower cost and time involved to meet the desired goals through strategies are dis proportionally high.

For the mother package of service are immunization prevention and treatment of anaemia, antenatal care and early identification of maternal complication, deliveries by trained personal promotion of institutional deliveries, management of obstetric emergencies, birth spacing.

Women are more vulnerable to anaemia because their needs of iron are greater then those of adult men. Women having closely spaced pregnancies are particularly at risk 2.

National nutritional anaemia prophylaxis programme has been in operation for a number of years. The programme aims at provision of
iron and folic acid supplements to the ‘high risk’ group identification and treatment of severely anaemia cases and promotion of the consumption of iron and promotion of the consumption of iron rich food. Change in dietary pattern is a long term strategy for prevention of anaemia.

Severe anaemia is pregnancy is associated with increased risk of maternal mortality causing an estimated 80,000 maternal deaths every year, high incidence of premature delivery, low birth weight, perinatal mortality and foetal wastage.

Severe anaemia is important risk factors in pregnancy. Reports from India indicated that 16% of all maternal deaths are attributable to anaemia. Maternal anaemia also contributes to an increase in perinatal mortality, low birth weight and factor wastage.

In the past, several studies have shown that iron deficiencies anaemia often leads to irreversible impairment of the Child’s learning ability and behavioural abnormalities.

Such losses are proportionally less in women (0.7 to 0.8 mg/d). menstrual bleeding causes an additional loss of 0.4 to 0.5 mg iron daily amounting to a total loss 80 µg/Kg/day. Women also lose iron to the placenta and the foetus, amounting to about 1.3g of iron as the cost of normal delivery.

Social and psychological factors leading anaemia among rural women in Jhansi District
Generally the rural women are suffering from anaemia due to imbalance diet and lack of awareness.

Medically speaking Anaemia is considered as a condition of reduction in the concentration of haemoglobin in the peripheral blood the normal for the age and sex.

According to Erslev (1977) it is a condition characterized by haemoglobin concentration below normal level which the patient suffers from tissues hypoxia due to low oxygen capacity of the blood.

A WHO export group proposed that, “Anaemia of deficiency should be considered to exits” when haemoglobin is below the levels.

Anaemia, due to iron deficiency is particularly common in women of the reproductive age group and young children. Surveys of haemoglobin levels of population in different area reveals that 88% among pregnant women suffers from anaemia and about 26% have severe anaemia.

The term anaemia has been defined as disminution in the oxygen carrying capacity of blood or in other words dissimulation capacity of blood or in other words, diminution below normal in the total circulating haemoglobin mass. The haemoglobin concentration is accepted as one or the indicators for the qualitative and quantitative assessment of anaemia in general, “Degrachy”, defined anaemia as ‘a
condition of reduction in the concentration of haemoglobin in the peripheral blood below normal for the age and sex of the patient various attempt have been made to classify from time to time.

Since then, there have been several report of the various retinal manifestations seen in anaemia. In a major study of 152 anaemia patients. "Holt" attempted to define the incidence of retinopathy in the various disorders of blood. Whether lesion were of any diagnostic importance, and whether these abnormalities could be related to blood counts and prognosis. He found that 51 patients have retinopathy, which was diagnostic of the underlying anaemia.

Blood contains a fluid called plasma that includes three different types of cells. White bloods are port of the bodies immune system and defined it against infection.

Red blood cells are produced in the bone marrow vast quantities (million) of new cells are produced each day to replace old cells that break down. Nutrient from food, such as iron and certain vitamins, insure that your bone marrow remains healthy and is able to produce a constant supply of red blood cells.

The red blood cells rely on iron to help them store and carry oxygen to every part of the body. If there is a lack of iron in your blood, your organs and tissues will not get as much oxygen as they usually do.
Anaemia is a condition which there is a reduced number of red blood cells or haemoglobin concentration.

There are several different types of anaemia, and each one has a different cause. The most common form of the condition is iron deficiency anaemia. This is where your body lacks enough iron to keep the red blood cells functioning properly.

Iron is key component of haemoglobin, the substances which helps to store and carry the oxygen in red blood cells. Without enough iron, your blood cells will be able to carry less oxygen to all of the body’s tissue and organs.

Other forms of anaemia can be caused by lack of vitamins B₁₂ or folate in your body. This health encyclopedia topic concentration on iron deficiency anaemia. For more information about vitamins B₁₂ and folate deficiency anaemia, see ‘anaemia’, vitamins B₁₂ and folate deficiency in the ‘related articles’ section.

Treatment for iron deficiency anaemia is usually very effective and the condition rarely causes and serious complication your blood may need to be monitored every few months after your diagnosis, to check that your are responding to treatment and that your iron levels returned to normal.
The end of iron deficiency is nutritional anaemia which is not disease entity. It is rather syndrome caused by malnutrition in its widest sense. Besides anaemia, there may be other functional disturbance such as impaired cells – mediated immunity, reduced resistance to infection increased mortality and mortality and diminished work performance. Vitamins B_{12} deficiency is associated with megloblastic anaemic, demyelization neurological lesion in the spinal card and infertility. Dietary deficiency of B_{12} may arise in subjects who are strict vegetarians and eat no animals product. Nutritional anaemia affect all age groups.

Through some studies on anaemia and it various associated epidemiological factors have been carried out so far, however the literature on the subject it still very scanty. Further, studies form developing countries like India, where anaemia of pregnancy poses a great problem have been very few.

The most common symptoms of iron deficiency anaemia include.

- Tiredness
- Lethargy
- Shortness of breath and
- Palpitations (irregular heat beat)
Less common systems of iron deficiency anaemia includes:

- Headache
- Ringing in your ears
- An altered sense of tast
- A desire to eat non-food items, such as ice, paper or clay (pica).
- Sore tongue and
- Difficulty in swallowing

You may also notice changes in your physical appearance, for example, signs that you may have iron deficiency anaemia include:

- Pale complexion
- Abnormally smooth tongue
- Painful ulcers on the corners of your mouth.
- Dry faking nails and
- Spoon shaped nails

Many people with iron deficiency anaemia will only display a few signs or symptoms of the illness. These severity of your symptoms may also depend on how quickly your anaemia develops. For example, if your anaemia is being caused by a chronic slow loss of...
blood such as a stomach ulcer then you may notice very few symptoms, or they may developed gradually.

Amongst various studies it has been found that anaemia is a general indicator of poor health and it is closely linked with poverty and malnutrition.

Social factors of maternal mortality are age of child birth, purity too close pregnancy family size, malnutrition, poverty illiteracy, ignorance & prejudices, lack of maternal services, storage of health, manpower, delivery by untrained dais, poor environmental sanitation, poor communication & transport facility, social customs etc.

Pregnancy anaemia is emerging as a most important cause of maternal morbidity and mortality in all developing countries. Indian data show that at least 50% of pregnant women are anaemic.1 Anaemia results in intra-uterine growth retardation, small babies, preterm labour and increased risk of sepsis. The pregnancy anaemia is largely nutritional in origin. The pregnant woman becomes anaemic because of increased demand of iron during pregnancy, pre-existing negative iron balance due to frequent pregnancies, menstrual blood loss, dietary inadequacy, helminthiasis, etc. The nutritional anaemias are largely due to deficiency of iron and folic acid.
Iron deficiency and iron deficiency anaemia are not synonymous. In fact anaemia is a very late manifestation of iron deficiency. The individual is born with minimal or nil iron stores. The body starts storing iron after birth and it is estimated that storage iron in man reaches 800-1000 mg by the time he reaches adulthood. In female the storage iron is 400-600 mg only. This storage iron helps in times of crisis and maintains haemoglobin values to normal level. In India and in many developing countries, women are not able to build their iron stores because of poor nutrition, repeated infections, menstrual blood loss and repeated pregnancies. A study of serum ferritin levels in resident doctors, nurses, male resident doctors and pregnant women was undertaken. Serum ferritin is a very sensitive index of iron stores. Serum ferritin levels below 20 ng/ml suggest severe depletion of iron stores.

The study showed that serum ferritin levels were less than 20 ng/ml in 60% of pregnant women, 55% of nurses and 40% of lady doctors. Only 10% of the male doctors had the serum ferritin levels below 20 ng/ml (Table 1). The data clearly show that most women have very meagre iron stores and results in overt iron deficiency in conditions with increased demand of iron. It is important to diagnose iron deficiency in its early so that treatment could be initiated in time.
Table - Showing Serum Ferritin Values

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<tr>
<th>Serum Ferritin (mg/ml)</th>
<th>Nurses (n=40)</th>
<th>Lady doctors (n=30)</th>
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Dietary factors is also very important factor of anaemia. In dietary factor including dietary habits Upadhaya (1994) observed that there was no cases of anaemia in the non-vegetarian group, which used meat, fish stuff in additional to vegetable diet.

A study of dietary intake in Gauri village of Lucknow (Singh et al., 1971) revealed that the majority of the population was vegetarian consumed hardly any flash food.

Dietary inadequacy is the main cause for the high prevalence of vitamins A deficiency and iron deficiency, characterized by poor iodine deficiency, characterized by poor iodine content in soil leading to deficiency of iodine in food and water is responsible for IDD.
Maternal malnutrition delayed and inadequate supplementation, frequent childhood infections, avoidance of micronutrient – rich foods due to ignorance as a result of high female illiteracy, poor bioavailability of dietary iron and low purchasing power of families are the important causes of vitamins A and iron deficiency.

Iron deficiency anaemia occurs when the body does not enough iron. A lack of iron in your body can be caused by a variety of factors. Some of these factors are outlined below.

- **Gastrointestinal blood loss**: Bleeding in the stomach and intestines is the most common cause of iron deficiency anaemia in men, and is also the most common cause for women who have been through the menopause.

- **Non-steroidal anti-inflammatory drugs (NSAIDs)**: If used for a prolonged period of time, in high doses, NSAIDs can sometime cause bleeding in the stomach. Ibuprofen and aspirin are example of commonly prescribed NSAIDs.

- **Stomach ulcers**: A stomach ulcer can occasionally cause your stomach lining to bleed. In some cases, this may cause you to vomit blood, or to pass blood in your stools. However, if the ulcer is slow symptoms, your may not display these symptoms.
Either way, the blood loss from the stomach can cause your to develop anaemia.

- Cancer: If your GP suspects that cancer may be a cause of your gastrointestinal bleeding, you will consult specialist for a more through examination. This way, if cancer is found, it can be diagnosed and treated as quickly as possible.

Menstruation: Menstruation is the most common cause of iron deficiency in women who have yet to go through the menopause. Usually only women with particularly heavy periods develop iron deficiency anaemia. If you have heavy bleeding over several consecutive menstrual cycles. It is knows as menorrhagia.

Pregnancy: It is very common for women to develop iron deficiency during pregnancy. This is because your body needs extra iron so that your body has a sufficient blood supply and received all of the necessary oxygen and nutrient. Many pregnant women require an iron supplement, particularly from the 20th weeks of pregnancy.

The time interval between an obstetric emergency and death is a complex interplay of Sociocultural, logistics and health service factors. The low status of women makes their illness low on the family priority list especially when financial and opportunity costs are
involved, thus delaying the decision to seek care. The woman even when educated, is unlikely to be the decision maker when she herself is sick or moribund and she has to depend on the whims of the real decision makers like her mother-in-law or husband. Hence the husband's education becomes an important determinant in survival. Cultural perceptions about illness also play a role in delayed treatment seeking eg, in certain communities in West Africa prolonged labour is considered a sign of the woman's infidelity to her husband and in many parts of western India, PPH (postpartum haemorrhage) signifies cleansing of the body by removal of bad blood.

Cultural factors are modified by practical considerations like the distance from the health facility, and the effort and "time that would have to be expended in reaching there. Perceptions about the efficacy and quality of the care that will be received also determine utilisation. A study done in the USA found a very high maternal mortality rate (92 times higher) in a religious sect which does not believe in using modern obstetric care. This was despite the fact that the community is affluent and well educated.

Most nutrition interventions in developing countries have been designed primarily to reduce malnutrition among children. Even
programmes which include women tend to focus on pregnant and lactating women. This approach limits the success of interventions since action to improve nutrition-related reproductive outcomes is most effectively implemented before women become pregnant, and preferably should be undertaken before girls reach reproductive age. The different circumstances of men and women in developing countries affect women's nutrition, and it is necessary to take such differences into account when designing nutrition interventions. The major nutritional deficiency diseases of concern in the developing world are protein-energy malnutrition (PEM), iron deficiency anaemia, iodine deficiency disorders (IDDs), and Vitamin A deficiency. All four show gender differentials in prevalence and severity, with three of the four representing a more serious problem for women than men: the prevalence of PEM is significantly higher among women in South Asia (where almost half of the world's undernourished people lives); both iron deficiency anaemia and goitre are more prevalent among adult women than men, although vitamin A deficiency appears to be more prevalent among boys than girls. A dearth of good epidemiological data on adult nutritional status, and lack of appropriate reference standards, make it difficult to estimate accurately the extent of malnutrition among women in the developing world. Conservative
estimates suggest that of the 1130 million adult women living in developing countries in 1985, over 500 million were anaemic due to iron deficiency, almost 500 million were stunted as a result of childhood PEM, about 250 million at risk of disorders due to severe iodine deficiency, almost 100 million suffering from goitre, and almost 2 million blind due to Vitamin A deficiency. A problem of this magnitude cannot be dealt with through narrowly targeted feeding programmes for pregnant and lactating women, or by relying on the long-term effects of economic development programmes.

Data from 32 studies examining PEM among women in developing countries established that women generally consumed only about two-thirds of the WHO recommended daily allowance for energy, and that their average weight-for-height was well below the average for small-frame women in the US. Other studies have established that the energy-intakes of pregnant and lactating women only marginally exceed those of nonpregnant, nonlactating women. The long-term negative reproductive consequences of childhood PEM are fairly widely accepted. It is well established that stunted women are at higher risk of obstructed labour, itself a major cause of maternal mortality.
Iron deficiency anaemia is the most widespread nutritional problem among women, and has severe consequences for both their reproductive and productive roles. Maternal mortality rates are significantly higher among anaemic women, as are prematurity and infant mortality rates. Although there is limited direct evidence concerning the effect of anaemia on women's physical work capacity, research on men shows a clear association between iron deficiency anaemia and reduced work capacity. Because low-income, rural women living in the tropics experience the highest rates of iron deficiency anaemia (along with other forms of malnutrition and morbidity, and also some of the most physically demanding work responsibilities (including weeding, threshing, pounding, fetching fuel and hauling water), it is probable that anaemia among women accounts for a significant loss of productivity, and therefore of family welfare, in developing countries.

Iodine deficiency disorders are of particular concern since they can result in severe negative reproductive outcomes for both mothers and infants. Evidence from 19 studies shows that prevalence of goitre appears to be higher among women, with the gender differential first appearing in adolescence and becoming much more pronounced among adults. Severity increases in women with increasing age, but

Social and psychological factors leading anaemia among rural women in Jhansi District
declines significantly in males after adolescence. Although the reasons for higher prevalence and greater severity of goitre among women are not well understood, similar patterns in developed and developing countries suggest that at least part of the reason can be attributed to biological differences, perhaps aggravated by socioeconomic or behavioural factors.

Adolescent mothers are more likely to have low birthweight infants. This is due to a combination of shorter average maternal height, competition for nutrients between the still-growing mother and the fetus, and poorer placental function in adolescents. Interestingly, adolescent mothers need to gain more weight than older mothers to have a normal weight baby. Concurrent pregnancy and growth in low-income adolescent girls also has a significant negative effect on the micro-nutrient status of these mothers.

Two aspects of the status of women appear particularly relevant as probable indirect determinants of their nutritional status. The first is the cultural importance of childbearing in terms of a woman's status and her fulfilment of family expectations. In developing countries, women are usually under considerable pressure to bear children, sometimes to the extent of having as many, closely-spaced children as
possible. Another aspect affecting nutritional status is gender bias (where it exists) in intrahousehold food distribution. Some studies, based primarily on data from South Asia, have found less adequate consumption of nutrients on the part of adult women compared with men. While lower requirements may provide a partial explanation, it is unlikely that they account for all or even most of the generally poorer dietary intake of women, particularly since women often work longer hours and/or do more strenuous work than men.

Food proscriptions also affect women's nutritional status. Most societies have recommended dietary practices for pregnancy and lactation, and there is evidence from numerous cultures that meat and other high-protein foods are withheld, sometimes from women in general but most frequently from pregnant and lactating women. Women may themselves restrict their food intake during pregnancy to reduce fetal size and facilitate delivery. The effects of these practices on women's nutritional status are not known.

The lives of women in developing countries differ from those of men for cultural, biological and socioeconomic reasons. These differences place women at significantly higher risk than men of malnutrition and mortality. The importance of women's nutritional

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Social and psychological factors leading anaemia among rural women in Jhansi District
status to their own health, productivity, and quality of life, and to the survival and healthy development of their children and other family members who depend on women's domestic and market work, warrant serious efforts to reduce malnutrition among women.

Inadequate nutrition in women is often a function of gender biases in access to food and health care. Where early marriage is practised, this deprives women of the benefits of education and the nutritional awareness it may bring. Poor women in India and Pakistan are often exposed to the double energy demands of gruelling agricultural work along with early and frequent childbearing.

Studies in Punjab, India, show that social discrimination against young girls in nutritional matters has persisted despite agricultural growth and economic development in the area. Even in privileged families, some girls may be malnourished. Indeed, the gender differential in food consumption among children from birth to four years was higher among landed classes than in landless families, with evidence of selective discrimination against daughters of second or higher birth order. This suggests that demographic transition in the region has worsened the status of female children, since their mothers continue to be under great pressure to bear and nurture sons. In West
Bengal, general village improvements have resulted in better nutritional status for boys, but not for girls. Additionally, women receive a disproportionately small share of household food, despite their greater energy expenditure on household and farming activities.

Gender differences in women's childcare and feeding practices are established early. Girls are breast-fed less frequently, for shorter durations, and over shorter periods than boys. Weaned early, they may not receive sufficient quantities of supplementary food. Documentation of the quality of food in several cultures has shown that male children generally receive more cereal, fats, milk and sugar than female children. Higher calorie and protein intakes by males of all ages have been documented for Bangladesh. Girls' lower levels of health care, combined with differences in feeding patterns, expose them simultaneously to higher rates of malnutrition and longer periods of more severe morbidity, contributing to their significantly higher mortality.

Low food intake during pregnancy is common in both India and Pakistan. Studies have shown that women consume little or no extra food during pregnancy, and may even consciously limit their intake for fear of large fetuses and difficult labour. Food taboos not only deprive
women of protein and iron sources, but also reduce calorie intake. In both countries, very high female mortality has led to an abnormally low female to male sex ratio C933 and 904 women per 1,000 men respectively in 1981. Seasonal shortfall in food availability tends to affect women disproportionately since their already inadequate intake will be curtailed drastically. Even when more food is available, it tends to be preferentially allocated to men, thus preventing women from accumulating any reserves. If seasonal shortfall coincides with pregnancy or lactation, the implications for women and infants are particularly harsh. These deep-rooted social prejudices are also seen in relation to women's access to and use of health services. One study found that while females outnumbered males four to three among children suffering from kwashiorkor, over 50% of related hospital admissions were boys. A survey in Maharashtra revealed that although higher percentages of girls were ill than boys, lower percentages received medical treatment in the under-15 age-group. Girls tend to be taken to less qualified doctors than boys, and have less spent on medicine for them. In general, better and more timely medical care for boys may be the main factor accounting for the higher survival rates among males.
These trends demonstrate that households discriminate against female children in relation to health care in much the same way that they do in nutritional matters. These patterns continue in adulthood. A larger proportion of adult women than men receive no treatment, and women tend to be treated mainly through home remedies or traditional medical care, while men receive institutional care. Hospital, clinic and primary health centre records in India and Pakistan invariably show that a greater number of males than females receive treatment as many as five times more. Female illness is, however, frequently underreported due to women's reluctance or inability to seek medical care, or deliberately downplayed due to constraints such as time, expense, or stigma. This can become a vicious circle as untreated female illness causes increased morbidity.

As women continue to bear the brunt of the hard labour in poor countries, it is important to foster the concept of improving women's nutrition and health for the sake of women themselves, rather than just for that of their children. The nutritional status of women during adolescence could be improved considerably, with spin-off benefits for their future infants. In the short-term, supplementary meal programmes for adolescent girls could have long-lasting benefits, while in the long term, structural and cultural changes are needed.
It is now acknowledged that malnutrition does not affect all members of a household equally, except in times of famine. Food is not equally divided within households, but reflects the order of precedence and perceived social value of the consumers, as well as factors such as religious practices. Studies of food distribution in both developed and developing countries note that food distribution based on sex differences always favours males. Unequal food distribution is further suggested by differences in morbidity and mortality within households. Effective development interventions therefore require knowledge of household resource allocation patterns. This is important given the heavy workload borne by poor women in both rural and urban settings.

Preferential food distribution refers to increased quantity and/or quality of food, as well as less obvious factors such as serving priority. In many societies, it appears that behaviour rather than absolute quantity of available food determines nutritional status.

Distribution of food usually favours males as their economic contribution is thought to be greater. Some children may receive preferential treatment based on their anticipated future contribution to the household. In Nepal, existing evidence points to age, sex, and
perceived current and future economic contribution as the primary individual characteristics determining intrahousehold food allocation patterns. This investigation of patterns of food distribution within households was carried out in six ethnically diverse hill villages in rural Nepal, using both anthropological and nutritional science methods.

In most of the households surveyed, the food servers were adult women. Young children tended to be served automatically, but those aged between 7 and 10 years served themselves more often than they asked for food. Food serving methods varied substantially by sex from early adulthood. Men, unlike women, were served automatically and with increasing frequency. This trend continued into old age. Women were much less likely to be served, and usually served themselves. Guests were frequently required to eat second helpings, whereas lower status household members had to ask for more. This becomes important when there is little food available for second helpings. Second-helping scores for young women were particularly low, leaving them nutritionally vulnerable at an age where they marry and move into their husband's home. There they have very low status; as junior females in the household, they are served automatically but are expected not to ask for food. When their status rises to that of food

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server, their access to food increases. The server's access to leftover foods from other household members also contributes to their score.

Senior males were observed to receive large portions of a desirable food while adult women received a disproportionately small share. Food proscriptions applied mainly to women, and appeared to have an overall negative effect on women's dietary diversity and intake. The following foods were often served to other household members and not to adult women: soybeans, wild green leafy vegetables, potato pickle, banana, mango, fish, eggplant, cow milk yoghurt, cow milk ghee, buffalo milk, and chili. Women consumed wheat products, pork, chicken, eggs and liquor even less frequently. Some foods, considered difficult for infants to digest, were avoided by nursing mothers. Foods in this category are not in short supply and there is no reason to avoid them apart from food belief systems. Animal products are in high demand and short supply, and preferentially distributed to adult males and small children. Channelling food away from women therefore appears to be due to a combination of food beliefs and low status.

Examining calorie intake, beta-carotene intake, riboflavin intake, and vitamin C intake, adult women scored lower than children and
males for all substances. This raises concern about the nutrient intake of adult women, who have active daily work routines, culturally prescribed dietary restrictions and additional nutritional needs if pregnant or lactating.

Female labour is crucial for the production of men's cash crops. But it is now also vital that women derive a cash income from trading if they are to purchase additional food and other household necessities. Although women's cash income is comparatively smaller than men's, it is often more significant in terms of a family's standard of living. Moreover, women spend their incomes on the family, whereas men tend to spend theirs on themselves. Women may in fact remain free to spend their own income only because men recognize that they are reinvesting it in family needs, and not accumulating capital independently. Male earnings and social activities, particularly the consumption of alcohol, are becoming increasingly detached from family activities and responsibilities, and are often reported by women to be a serious drain on household income and resources. Women's heavier responsibilities, and the difficulties they experience in carrying them out, lead to conflict between their various roles and reduce their limited leisure time. Dietary practices have further health implications since women customarily allocate more and nutritious food to men,
while making do with bulky, low-calorie staples themselves. Food taboos, which most often relate to high-protein foods, apply least often to adult males. Few men seem aware of the potential nutritional deficits of their wives and children.

Behind most food security policies lies the assumption that once a household obtains sufficient food, all its individual members will be adequately nourished. The Indian experience shows that improving a household's access to food does not guarantee that the women in the family will receive sufficient food. Gender bias in nutritional status and food distribution within the family has been recognized only recently, despite an abundance of data on the issue. With the advent of the UN Decade for Women, further research on female nutrition was undertaken, nearly all of which underlined the fact that most development initiatives had either ignored women, failed to recognize their particular problems, or even worsened their situation. Most nutritional surveys in India monitor the status of households rather than that of individuals, using the Consumption Unit which is based on norms rather than actual intake. One Consumption Unit is the recommended daily calorie intake of a male sedentary worker, and all other age-groups, sexes, and activity levels are taken as a proportion of this measure. There is little evidence that Indian women actually receive even this proportion of the family's food resources. Concern
over women's nutritional status is confined to pregnant and lactating women, their nutritional and health status prior to and after these stages receiving little or no attention. These women are defined, along with pre-school age children, as a "vulnerable" group and the traditional recommendation has been to provide supplementary nutrition to offset some of the ill effects of their nutritional status quo. However, this approach leaves the nutritional needs of the vast majority of poor women unaddressed, and provides a partial explanation of the declining female:male sex ratio, higher female infant mortality rates, and high maternal mortality rates.

There is plenty of evidence that the lower status of women in society is among the basic underlying causes of maternal malnutrition and women's poor health.

Lower status of women is well reflected in the fact that many societies prefer boys to girls, offer better education and job opportunities to men, pay women less for the same work, and often see them in less prestigious jobs with very little access to decision-making. In the poor rural areas of developing societies, women have a higher share of illiteracy, overwork, undernutrition as well as loss of traditional support systems and the burden of heading the household due to accelerating male migration.

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Women's status defines their position in society. It is both their standing as well as the perception in society as to where they actually belong. Women's status is often characterized through a set of social, political and economic indicators:

1. The group of political indicators consist of: (a) legal entitlements; (b) participation in the political process; and (c) authority through holding offices either via election or by appointment.

2. Indicators of economic position include: (a) participation in labour force; (b) job security; (c) wage rates; and (d) education and specialization.

3. Indicators of social position are: (a) marital relations; (b) maternity benefits; and (c) divorce, child custody and child care.

Historically, poorer women have had to work and have received few societal benefits. Interestingly enough, what is known about women is based on records and thoughts of men. It was only in the 18th century that women began to organize themselves around the issues of their own concerns. Their situation at that time has been described as fragile, domestic and dependent.

In the United States, change of women's status began in the 1920s and have continued ever since. Initially, women gained the right to vote, common access to primary education, and gradually improved
their social and economic position. Over the past two or three decades, women in the industrialized world have gained substantial social, political and economic rights. For instance, rights to equal job opportunity, equal pay, property and credit, as well as expanded educational opportunities, increasing political participation and organization, have been tremendous improvements. Family roles are changing too. For instance, substantial change in age at marriage (22 years in the USA), having the first child as late as 30 years of age, and sharing of men in child care and housework are to be noted.

In summary, women have gained status almost equal to men which, in the opinion of some experts, is not fully secure.

In the third world, attention to women's issues has been a much slower process. The UN Commission on the Status of Women was established in 1948. However, the first worldwide effort to enhance the status of women began with the UN Conference on Women in Mexico in 1975 and followed through with the UN Decade for Women 1975-1985.

Experts such as Margaret Leahy see a connection between the global concern over food and population issues in the sixties and a new level of attention to the women's issues. Actually, two major international conferences on food and population in the early 70s made
it clear that women have a central role in food production and fertility control, and there was an almost sudden awareness as to how little the world knew about women. It also became clear that success in policies and programmes geared to better nutrition, family planning and population control were heavily dependent on enhancing the position of women.

Since then, progress made in enhancing women's position has been reviewed in two major international conferences in Copenhagen (1980) and Nairobi (1985).

Important progress in the last ten years includes the following. First, the state of knowledge and information on the conditions of women in the world have improved dramatically. Second, the role and contribution of women to national development, family life and societal welfare is now much better documented and understood. In other words, the links between women's status and national development are clearer now. Therefore, women and women's advocates can be much more effective in defining women's issues and placing them on the national and international agenda. Third, substantial experience has emerged in numerous countries in dealing with women's issues from a variety of perspectives. Already, good beginnings have been made in many countries, and through persistence and hard work, much more could be achieved.
It has been argued that in the long run, industrialization and sustained national economic growth are the critical preconditions for enhancing the position of women. However, it is no secret that many developing countries have experienced serious difficulties in their efforts for industrialization and economic advancement. Furthermore, there are several serious barriers to women's participation in economic and political spheres.

Illiteracy and poor education lie at the heart of women's lower status. Today 27.7% of men and women are illiterate in the world. Table IX shows the alarming contrasts between the industrialized and developing world as well as those between women and men. Level of illiteracy in the developed world is only 1.7 for men and 2.6 for women. In the developing countries, illiteracy is 16 times higher for men and 20 times higher for women. In the least developed countries in the world, more than half the men and three-quarters of the women are illiterate. In the developing countries, there are almost two illiterate women for each illiterate man. Looking at the regions of the world, the highest illiteracy is found in African and the least in Latin America with Asia being somewhere in between.

In many traditional societies, education is considered as preparation to leave home while women's traditional place is at home.
This logic cuts across several social strata. It explains why more boys are sent to school in several classes, societies and regions of the world. A look at primary school enrollment shows that the female disadvantaged position is likely to remain for the next generation in Africa and Asia.

The primary school enrollment in the developed world is 92/92 for men and women, and in the developing countries it is around 79/66. In Latin America there is no gap between boys and girls and the ratio is 88/88, while in Africa and Asia respective rates are 72/60 and 81/65. Some experts argue that education gaps between men and women widened since boys gained access to the western-modeled education and girls did not. This is particularly true in the Islamic nations. Women's education in all probability is a critical precursor to closing the gender gap, facilitating their political participation and moving them from the periphery to the mainstream of development. Educated women are much more effective in their own welfare as well as that of their family. At the very basic level, illiterate women often find it hard to absorb modern methods of sanitation, management and prevention of disease, nutrition, fertility regulation and pregnancy care. Women with no education are more apt to embrace the traditional status quo and less open to change for better health and family practices.
Furthermore, the prevalent social attitudes towards the role of men and women and sometimes the religious teachings play a strong role in conditioning women's economic and political position. In societies where the appropriate social role for women is perceived to be a wife and mother, then it becomes extremely difficult for them to expand their economic role and social mobility. Under such circumstances, women are primarily responsible for the reproductive process while being denied the right to control it.

The discussion thus far indicates that future positive change in status of women is primarily a matter of education, empowerment through organization and political participation, change of attitudes in society and economic control.

Unfortunately, there is no clear and conclusive analysis as to whether any of these variables function as precursor to the other. However, industrialization, economic growth, combined with education and empowerment of women, could result in better social and economic positions for them.

The clearest indicator of discrimination against Indian women is the skewed sex ratio. There were only 927 females per 1000 males in India (the world average is 990 women per 1000 men), according to

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the 1991 Census. Provisional figures for Census 2001 indicate that the trend has been slightly arrested, with the sex ratio at 933 females per 1000 males, with Kerala at 1058 females.

Yet cause for concern remains. The sex ratio of the 0-6 age group has declined sharply from 945 in 1991 to 927 in 2001. One reason for the adverse juvenile sex ratio is the increasing reluctance to have female children. Portable ultrasound machines and sex determination tests have made possible to detect and abort the female foetus. Social neglect of women (and girls is the other contributing factor.

Poverty, early marriage, malnutrition and lack of health care during pregnancy are the major reasons in both maternal and infant mortality. In rural India almost 60 per cent of girls are married before they are 18. Nearly 60 per cent of married girls bear children before they are 19. Almost one third of all babies are born with low birth weight.

Maternal mortality in India is the second highest in the world, estimated to be between 385-487 per 100,000 live births. Close to 125,000 women die from pregnancy and pregnancy related causes each year. Antenatal services are poor with only 53.8 per cent receiving
tetanus toxoid injections and 46.8 per cent having their blood pressure measured. 80 per cent of women are anaemic. As many as 58 per cent reduce their food intake during pregnancy instead of increasing it. Two-thirds of deliveries still take place at home, with only 43 per cent supervised by health professionals. Only 52 per cent of couples in the reproductive age groups use contraception.

For the country as a whole, nutritional standards are poor with cereal consumption per capita having fallen from 17 kgs per month in 1952 to 13 kgs per month in 1993-94. Calorie intake has also declined. Forty percent of males and 41 percent of females suffer chronic energy deficiency. A shocking 50 per cent of [Children fewer than five are malnourished and 70 percent anaemic because of nutrition deficiencies. Anti-people policies alone can explain the paradox of tonnes of grain rotting in FCI godowns while people go hungry.

Poverty and lack of awareness also hinder mothers from giving adequate care for their children. For instance, although diarrhoea is the second largest killer of babies, only 43 per cent of mothers know about ORS and only 26 per cent report ever having used it. Similarly, only one-third of children are fed complementary foods between the ages of six and nine months when breastfeeding should be supplemented. The

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second National Family Health Survey suggests that uneducated mothers tend to lose the most infants.

Social restrictions on women's mobility also 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 30 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.

The privatization of the health sector has increased the burden of the poor. Studies suggest that illness is the second highest cause for rural indebtedness. Government spending on public health fell from 1.26 per cent of GDP in 1989-90 to 1.12 per cent of GDP in 1995-96. Only 50 per cent of villages have any government health facility.

Only 62.3 per cent of Indian households have access to safe water -- 81.4 per cent urban and 55.5 per cent rural households. This
means that women spend a considerable amount of time carrying water from distant wells and other sources, adding to women's burden.

Access to sanitation facilities is a special problem for women and girls, given the social emphasis on privacy and seclusion. Having to go out exposes them to harassment. Women and girls living in urban slums are particularly affected. Public toilets for females are few. Many schools do not have toilets for girls and women teachers. By 1995 only 15.2 per cent of rural people had access to toilets.

In 1951, shortly after Independence, the Census recorded that only 25 per cent of men and 7 per cent of women were literate. By the 1991 Census, female literacy had risen to 39 per cent. Census 2001 provisional figures indicate that 54.16 per cent of women are now able to read and write. Still, 245 million Indian women cannot read or write, comprising the world's largest number of unlettered women.

National averages in literacy conceal wide disparities. For instance, while 95 per cent of women in Mizoram are literate, only 34 per cent of women in Bihar can read and write.

Since the majority of India's unlettered people are female, literacy and education programmes need to focus on girls and women. Yet progressive government programmes like the Mahila Samakhya, that designed a scheme to conscientise and empower rural women.
women and motivate them to educate themselves, have been distorted in recent years. The District Primary Education Programme focuses on enrolment but not on the retention of girls in schools. In the absence of an enabling and empowering environment, girls are unlikely to stay on in school, say critics of the large World Bank funded programme.

The average Indian female has only 1.2 years of schooling, while the Indian male spends 3.5 years in school. More than 50 per cent girls drop out by the time they are in middle school.

Women's organisations point out that sibling care is a major reason for girls dropping out of school and suggest that creches be attached to schools so that girls are free to attend classes. Midday meals, free books and uniforms, and the provision of toilets are other facilities suggested to bring more girls into the school system, besides more same sex schools and more female teachers.

The women’s movement has repeatedly called upon the government to fulfill its pledge to invest 6 per cent of the country's GDP in education. But in fact expenditure on education fell from 3.4 per cent of GDP in 1989-90 to 2.8 per cent in 1995-96. Further, amounts actually made available and real spending falls far short of budgetary provisions.
Most of the work that women do, such as collecting fuel, fodder and water, or growing vegetables, or keeping poultry for domestic consumption, goes unrecorded in the Census counts. Many women and girls who work on family land are not recorded as workers. In 1991 women and girls comprised 22.5 per cent of the official workforce. Data from the National Sample Surveys records higher work participation by women than the Census.

Women constitute 90 per cent of the total marginal workers of the country. Rural women engaged in agriculture form 78 per cent of all women in regular work. They are a third of all workers on the land. The traditional gender division of labour ensures that these women get on average 30 per cent lower wages than men. The total employment of women in organised sector is only 4 per cent.

Although industrial production increased in the 1980s, jobs in factories and establishments or non-household jobs -- stagnated at eight per cent of the workforce. Increasingly, companies tend to rely on outsourcing, using cheap labour.

It is well known that women and children work in huge numbers in bidi-rolling, agarbatti-rolling, bangle making, weaving, brassware, leather, crafts and other industries. Yet, only 3 per cent of these women are recorded as labourers. They are forced to work for pitiable wages.

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and are denied all social security benefits. A study by SEWA of 14 trades found that 85 per cent of women earned only 50 per cent of the official poverty level income.

Crime against women has been rising with each year. Violence, both outside and within the household, is a grim reality of women's lives. Between 1990 and 1996 crimes against women grew by 56 per cent. Cruelty to wives comprised 28 per cent of all crimes in 1996.

The extent of trafficking in women is unknown. However, one official study admits to 100,000 prostitutes in six metro cities. Of these, 15 per cent are girls below the age of 15. Cross-border trafficking is common.

According to the National Sample Survey Organization figures, one out of ten households is headed by a woman. Women-headed households include widows, deserted and divorced wives and single women. They tend to be among the poorest households in the country. There are indications that the number of such households is rising and that the NSSO figure is an underestimate.

The status of tribal women is in some ways better than that of other women, for instance, female infanticide is lowest among the tribal people. Tribal women work shoulder to shoulder with men and
have a higher status than many caste Hindu women do. Still, violence and oppression is a common occurrence. They are doubly oppressed as part of a community that is among India's most deprived people. Their customary access to the forests has been restricted with the government appropriating forests and forest produce through a series of damaging legislations. Large numbers of tribal people have been displaced from their homes by modern so-called 'development' projects including mines, giant industrial plants, dams and electricity projects as well as defense installations like missile ranges.

Women have equality of status under the country's Constitution. However, many anomalies remain under different laws.

During the 25 years of the women's movement the government has amended several laws that affect women, including laws related to dowry, rape, cruelty, maintenance, prostitution and obscenity. India has ratified international conventions such as the Convention on the Elimination of Discrimination against Women (CEDAW). It has set up family courts in some states and the judiciary has issued a series of progressive judgments in favour of women, including a recent judgement on sexual harassment at the workplace and on child custody.

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However, Hindu law still does not give women equal rights in ancestral property. For instance, they cannot be coparceners in ancestral property and have limited rights to inherit it. They cannot ask for division of the property. No law exists to prevent wives from being thrown out of the matrimonial home. Separated, deserted or divorced women face major hurdles in claiming maintenance for themselves and their children.

The government has been singularly reluctant to address the issues of minority women's rights. The constitutional stipulation to chart a Uniform Civil Code has been unsuccessful so far because, by and large, the effort has been to impose Hindu law in the name of a Uniform Code and to ignore even the positive aspects of Personal Laws of other communities.

Although Indian women played a major role in the freedom movement, it did not translate into continued participation in public life in the post-independence era. On the contrary, many women withdrew into their homes, secure in the belief that they had ushered in a democratic republic in which the dreams and aspirations of the mass of people would be achieved.

Representation of women in the state legislatures and in Parliament is low. Women currently comprise 5.9 per cent of Lok
Sabra members. In the 1999 elections a mere 6.5 per cent of candidates were female.

Women have persistently lobbied for the passing of the 81st Amendment Bill, drafted in 1996, that proposes the reservation of one-third of seats in the Lok Sabha. But political parties have repeatedly sabotaged attempts to have the Bill approved.

However, hope lies in India's huge experiment with grassroots democracy through the panchayats. Nearly a million women have entered the panchayats and local bodies, thanks to one-third reservation in these bodies through the 73rd and 74th Amendments of the Constitution. Women head one-third of the oanchayats and are gradually learning to use their new prerogatives.

Both research and activism has focussed on the negative fallout of the process of globalisation and liberalisation on women. They have demanded that the investment in the social sector be increased. But a government bent on opening up the economy to foreign investment and free trade has paid no heed to these voices, although India has experienced industrial recession and a period of jobless growth in the past decade. Given the high levels of the population and a large population below age 20, the demand for employment is growing and
joblessness and accompanying frustrations have contributed to violence, frequently expressed as ethnic, caste, class or communal conflicts. Women are the worst sufferers in such conflicts.

Besides raising these economic issues, sections of the women's movement are questioning the oppression of Dalit women. Muslim and Christian women are strongly demanding equal rights.

The war in Kargil has spurred activism for peace. Women were the first to lead a peace delegation to Pakistan in the post-war period, breaking the ice and initiating people-to-people dialogues. Issues of conflict and peace are important, given the tremendous suffering of women in Jammu and Kashmir and in the North East region.

Cross-border trafficking of women and girls is a major problem that remains untackled. Lobbying by women's groups of the South Asian region forced the SAARC countries to include in their Male Declaration of 1997 a paragraph on trafficking and a commitment to sign a regional convention on trafficking. This commitment has yet to be fulfilled.

The Constitution had promised free education for all Indian children up to the age of 14. This promise was never fulfilled. The government is contemplating passing a law to grant children ages 6-14
the right to education. Child rights and women's activists argue that this right is already enshrined in the Constitution and the Right to Education Bill has been designed to absolve the government of its responsibility towards those under six years of age.

The National Commission for Women has made a series of recommendations for legal reform and other measures that deserve consideration but have so far been ignored by the government. Last year the Indian government reported to a UN Committee on the status of implementation of the Convention on the Elimination of Discrimination of Women and was congratulated for bringing women into panchayats, but criticised on other counts including denial of rights to minority women.

Activists have drafted a Bill on Domestic Violence after national consultations with women's organisations and lobbied for its passage. An official version is likely to be introduced in Parliament shortly.

The government has declared 2001 as the Year of Women's Empowerment or Swashakti. A policy for the Empowerment of Women was drafted in 1996 but has been in cold storage since then. It has recently, in March 2001, been passed by the Cabinet but has still to be made public. Even the Parliamentary Committee on Women's Empowerment has been denied the document.

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A pregnancy related death is the death of a women while pregnant or with in 42 day the cause of death. The international classification of disease has recommended the maternal death resulting from obstetric complication of the pregnant state interventions, omission, incorrect treatment of from chain of event resulting from previous existing disease or disease that development during pregnancy and which was not due to direct obstetric cause but which was aggregative by physiologic effect of pregnancy.

A woman's socio-cultural situation and her health are very closely inter-related. Earlier there was a tendency to view health purely in bio-medical terms, but there is an increasing awareness that a woman's health is a product of the complex social, economic and cultural (perhaps even political) circumstances in which she lives. While these factors affect the health of all individuals, they affect women's health more. Some of the different socio-cultural factors affecting women's health are as follows - financial status, education, religion, cultural mores, patriarchy, mobility and so on. Interestingly, socio-cultural conditions are not just contributing factors but also consequences of women's health situation. A small example will illustrate this situation. On the one hand son preference is one of the important reasons behind a woman undergoing repeated pregnancies and sex-selective abortions. On the other hand the inability to bear
sons, leads to a consequence where women have to face social alienation and even desertion.

With above view, a door to door research investigation on social & psychological factors leading to anaemia among rural women was carried out in rural population of district Jhansi.

Various researcher have been done to highlight the problems of women but very few attempts have been made to study the overall perspective of women is social psychological factors of anaemia.

This study has been attempted for the first time in Jhansi. District the factors leading anaemia of rural women in relation to various health problem which are present day part of the rural women.

Anaemia is very common health problem among rural women and hence the importance of this study increased automatically. First of all it has been found that in Bundelkhand region no such study has been attempted and data available regarding anaemia among rural women are scantily and rough estimate suggest that about 70% of the women in rural area of Bundelkhand suffers from anaemia. Therefore to get information regarding this problem will be helpful, this study shall be useful to planner, health administrator, health personnel, general peoples and research workers those who want to conduct similar studies. The valuable information of this study will also assist and provide new direction to those people who are working in the field of health.
OBJECTIVE OF STUDY:

- To study the socio-economic & demographic characteristics of women suffering from anaemia.
- To identify the main health problems among the women associated with anaemia.
- To assess social, economic, psychological and cultural factors leading anaemia among women.
- To assess nutritional diet of women.
- To evaluate the MCH(maternal and child health) services provided to women.
- To assess the health schemes initiated to improve the health status of women,
- To suggest measures for the improvement in health status of women in a studied village.