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HEALTH CARE FOR WOMEN : A PIE IN THE SKY

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Introduction

'Health is wealth' is an adage. A like Tamil proverb when translated into English connotes the same: 'Life without sickness is wealth without blemish'. These sayings express the concern of human beings about health. Nothing is more human, more personal than a sound health. Health in fact is and always has been one of the main preoccupations of the human community. We also exchange our good wishes with one another saying, "How are you?" and "How do you do?", referring to the health of the person. In this article we make an attempt to study how women as women are affected or discriminated against, in this essential service.

I HEALTH

i) Narrow View

In principle any deficiency in the function or well being is a health deficiency. The general approach to a definition of health is more negative. That is to say, health is viewed as the absence of impairments to person that are caused by disease and illness. On this view health is mere absence of disease and illness.[1] But

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[1] Tom L. Beauchamp, "Concepts of Health and Disease," in *Contemporary Issues in Bioethics* 3rd ed., ed., T.L. Beauchamp and Leroy Walters (Belmont: Wadsworth Publishing Co., 1989), 73-74.

freedom merely from disease and illness can by no means guarantee the well being of a person. Not all physically healthy people enjoy the well being that makes human life vibrant, creative, purposeful and fruitful.

ii) Broader View

In 1958 the World Health Organization gave a broader definition which is widely accepted. "Health is a state of *complete* physical, mental, and social well-being and not merely the absence of disease or infirmity."[2] This definition, though very attractive, is too ideal and hence is vitiated by its practical impossibility of realization.[3] After a thorough critical analysis of the WHO definition, Callahan gives his own definition. According to him health is a state of physical well being and that state of physical well being need not be 'complete', but it should be at least adequate, i.e., without significant impairment of function. Callahan also insists much on the physical well being to the exclusion of mental well being from health as if man is only a lump of flesh. Nonetheless his definition somehow comprises the social-well being. His definition tilts more to the general view of health even though his thinking is positive. There seems to be an absolutisation of bodily vitality in Callahan's definition.[4] This approach taken by Callahan has the weight of tradition behind it since in both the history of medicine and the history of philosophy, especially in the works of Plato and Aristotle, a mind-body dualism predominates

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[2] Benedict M. Ashley and Kevin D. O'Rouke, *Health Care and Ethics: A Theological Analysis* 2nd ed. (St. Louis: The Catholic Health Association, 1982), 3. (Emphasis added).

[3] For a detailed critical comment on the WHO definition of health, see Daniel Callahan, "The WHO Definition of 'Health'", in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed., Stephen E. Lammers and Allen Verhey (Grand Rapids, Michigan: William B. Eerdmans Publishing Co., 1987), 165-172.

[4] D. Callahan, "The WHO Definition of 'Health'", 172.

and health has primarily been viewed as physical well being[5]. But this traditional position holds water no more.[6]

iii) Comprehensive View

Health is not limited to human concerns. Animals too need health. Purely physiological health considered as bubbling vitality and freedom from pain, is too narrow and even too dangerous a concept. Such a definition will suit more the health of animals than of humans. This limited definition of health may actually stunt the human well being in its full sense for the simple reason that it may end up with an imbalance and under-development of the human person as an enfleshed spirit. Therefore as Haering points out health cannot be defined from a mere study of the body. We must consider the whole person in his human vocation and final destiny. This consideration takes us to a comprehensive approach to human health which has to comprise the greatest possible harmony of all of a person's forces and energies. In our day-to-day life too we speak not of the health of the body but of the person. Hence the rationality and necessity of a holistic view of health.[7] Obviously then mere bodily health is far less significant than psychological/mental and spiritual health. "Human life is misunderstood if there is interest only in the number of years and if medical care includes only condition of the body".[8] The three main dimensions of the human person as having a body, mind and spirit have to be accounted for when we consider the health of a person. They refer respectively to the physical/bodily health, mental/emotional health and spiritual health. Spiritual health predominantly belongs to the domain of religion and so it needs a

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[5] T.L. Beauchamp, "Concepts of Health and Disease," 74.

[6] Ruth Macklin, "Mental Health and Mental Illness: Some Problems of Definition and Concept Formation," in *Contemporary Issues in Bioethics* 3rd ed., ed., T.L. Beauchamp and L. Walters (Belmont: Wadsworth Publishing Co., 1989, p. 114-121.

[7] Bernard Haering, *Medical Ethics,* ed., Gabrielle L. Jean (Slough: St. Paul's Publications, 1977), 154-55.

[8] J.H. Van den Berg, *The Psychology of the Sickbed,* (Pennsylvania: Duquesne University Press, 1966), 57.

separate treatment. And therefore we pass over it here. However the other two aspects deserve some serious consideration with reference to the women of our country.

II HEALTH CARE OF WOMEN

Basic health care is the fundamental right of every human person. This health care has been consistently denied to an enormous number of people in our society. They are the women and the girl children. Analysis of the raw deal given to millions of women will point out the gravity of this health care problem.

i) Physical Health

a) Expectant Mothers

1. Malnutrition

Reproductive health of India's women deserves special attention. Good nutrition is necessary at all stages of life. Proper nutrition is absolutely necessary during pregnancy and lactation. During pregnancy extra nutrition is required not only for the growing foetus but also for the mother as she undergoes major changes. Any dietary deficiency affects both the mother and the child as early as twelve weeks of gestation and continues till delivery. An average Indian family consumes food that generally consists only of rice, roti, dal and curry which are not rich in proteins and fat necessary for the pregnant woman. Pregnant women are severely malnourished[9] especially in states like Bihar, Madhya Pradesh, Maharashtra, Rajastan, Orissa, Utter Pradesh.[10] A

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[9] Malnutrtion cases are divided into four grades. The first grade is called *mild malnutrition* which occurs when the person's weight is between 70 and 80 percent of the weight expected for that age. The second grade represents *moderate malnutrition*. Here the person weighs between 60 and 70 per cent of the average. In the third grade the individual's weight remains from 50 to 60 and in the fourth grade the weight is 50 per cent of the average. The third and fourth grades are considered *severe malnutrition*.

[10] Damodar Suar, "Discrimination against the Girl Child in India," *Social Action* 44 (July-Sept. 1994), 15-16; Lila Bavadam, "A Story of Neglect," *Frontline*, Oct. 11, 2002, p. 44.

study in 1982 brought to light that among girls less than fifteen years of age, 65 per cent in Hyderabad, 69 per cent in Delhi and 97 per cent Kolkata had Haemoglobin levels less than 11 gm per cent.[11] The normal level for a woman is 14. Since the mother-to-be is malnourished naturally the foetus falls an easy prey to congenital diseases like malaria and anaemia. Maternal deaths, like starvation deaths, when they are reported, are always explained away by the authorities as being deaths due to anaemia or some infectious disease. What is cleverly hushed up, however, is the fact that most of those who live below the fabled poverty line suffer endemically from severe to extreme under-nourishment. When this gets connected with repeated pregnancies, young mothers fall victims to various infections like malaria which play a havoc with their depleted immune system.[12]

2. Pathetic Medical Facility

Another way in which the health of the expectant mothers is neglected, is the malfunction of the health care centres. The auxiliary nurse mid-wives (ANWs) and other health workers in our government-run system become pliable instruments of the authorities. Pressure from the government and politicians living in urban capitals on the nurse mid-wives to achieve their targets in birth control hampers the work of health agencies especially in the remote rural areas. Two rounds of National Family Health Survey (NFHS) reveal that most of the nation-wide increase in contraceptive practices today is traceable to female sterilisation, i.e., tubectomy. After the backlash the post emergency period triggered against male sterilisation, the attention of the health workers shifted to women. Female sterilisation increased from 11 percent in the 1960s to 98 per cent at the end of the last century.[13] Therefore

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[11] S.N. Tripathy and Premanada Pradhan, *Girl Child In India* (New Delhi: Discovery Publishing House, 2002), 84.

[12] Mrinal Pande, "A Chronicle of Deaths Foretold," *The Hindu* (Sunday Magazine), April 15, 2001, p. 5.

[13] Promilla Kapur, ed., *Empowering the Indian Woman* (New Delhi: Publications Division, Government of India, 2001), 142.

trained auxiliary nurse mid-wives are kept busy filling endless registers, dispensing condoms and meeting the targets for tubectomy. This is very much in practice and overshadows the loudly articulated worries about women's health and human rights. Moreover these sterilisations are done at the cost of the vital ante- and post-natal care for women, eventually leading to failure to control either the 'unwanted' births or the maternal mortality rate.

When the balance of obligations of the health staff tilts towards achieving the birth control target another drastic effect is visible in the primary health centres and rural hospitals. All such health service centres are under-staffed, under-funded and under-equipped.[14] With the result unassisted births are taking a heavy tool of (hundreds of thousands of) young women each year. Dr. Vanava Pendse, former head of the department of Obstetrics and Gynaecology of the Udaipur Medical College observes that in all these maternal deaths the roll played by the irresponsible attitude of the health staff and the non-availability of proper health care and obstetric services is strong and evident. A report of the White Ribbon Alliance for Safe Motherhood (WRASM) confirms Pendse's observation. As per the report 15 per cent of the deaths of young women occur from complications related to childbirth and unsafe abortions, and over 80 per cent of pregnancy and childbirth deaths occur due to one of the following six causes – haemorrhage, eclampsia, obstructed labour, sepsis, unsafe abortions and pre-existing conditions such as anaemia, malaria or tubercular infections.[15] The death of their young mother doubles or even triples the threat to the life of children below five years of age, thus furthering India's already high infant mortality. What is tragic is that all these are preventable and treatable diseases. Had the trained auxiliary nurse mid-wives been in their centres most of the women could have been saved. Women in the rural areas are the victims of such callousness of the authorities and the health workers. And the rural women are mostly Tribals and Adivasis.

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[14] Dionne Bunsha, "The Excluded People," *Frontline*, June7, 2002, p. 46.

[15] M. Pande, "A Chronicle of Deaths Foretold," 5.

WHO reports that nearly 600,000 women die of diseases related to pregnancy and childbirth each year, with 99 per cent of the deaths occurring in the Third World countries. In India Orissa has the highest maternal mortality rate of 739 for every 100,000 live births, closely followed by Rajasthan with 677 while the national average is 540. Absence of basic health care services and emergency care adds to the cause of high maternal mortality rate. Thirteen per cent of the deaths are due to toxaemia of pregnancy and 23 per cent due to excessive bleeding both of which are diagnosed and treated early and efficiently in most countries giving priority to maternal health.[16] Other states with high incidence of maternal mortality are Uttar Pradesh, Bihar and Madhya Pradesh. Maternal mortality due to severe malnutrition and basic health care services is a particularly sensitive indicator of the inequality and discriminations heaped on women and shows that they lack access even to ordinary health care to which they have a right, and points out also the low priority given to the health care of women in the rural areas especially in many of the northern states.

b) Prostitution and Women's Health

Prostitution, though never accepted as part of the social mores, has been widely prevalent in all societies at every stage of civilisation as a quasi-institution. It is the lowest form of exploitation of women. According to a study conducted by the Tata Institute of Social Sciences there are approximately 2,000,000 prostitutes in India residing in 817 red-light areas, with more than 5,000,000 children labelled as illegitimate, the identity of whose fathers remains unknown even to the mothers. The number of call girls or high society prostitutes has not been included in this survey.[17] From the Indian Health Organization (IHO) some specifics about a few cities are also available. As per its study there

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[16] P. Kapur, ed., *Empowering the Indian Women*, 131-134.

[17] Rajita Das and Romila Chopra, "Prostitution: How to Deal with It?," *Social Welfare* 37 (June 1990), 2.

are over 100,000 prostitutes in Mumbai alone. The figure excludes of course the call girls. Kolkata too has an equal number of prostitutes while Delhi and Pune have an estimated 40,000 each. Nagpur, though a relatively small town also has 13,000.[18] Considering the sheer number of the persons involved, the problem of prostitution merits paramount consideration in every dimension of its existence especially from the health perspective.

For several well-known reasons very few studies have been done on the health status of these women. From the results available from the limited studies it is observed that about 90 per cent of the women in the brothels suffer from more than one disease – sexually transmitted diseases (STDs) like syphilis, gonorrhoea, genital herpes, and tuberculosis, scabies, anaemia, chronic pelvis infection and various other skin diseases.[19] Men who visit brothels are very likely to suffer from STDs. During their sexual activities they pass it on to these women. Gilada, a Mumbai-based physician in this field says that the majority of the prostitutes are treated by quakes who inject coloured water into the vagina for STD, deteriorating the poor women's health condition. Dharma Pal, adviser to the Government of India on STD confirms that only five per cent of the prostitutes go to government hospitals for treatment and are documented. The other 95 per cent go to private doctors or remain untreated. With the proliferation of the red-light area in Mumbai, Maharashtra alone accounts for 50 per cent of STD cases reported by government clinics. The Indian Health Organization states that on any given day the affected population of Mumbai touches nearly 36,000.[20]

c) Women and AIDS

It is very unfortunate that women in the brothels are more vulnerable to this killer disease. In India they are the most active

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[18] Raj Kumar, ed., *Women and Sexuality* (New Delhi: Anmol Publications, 2000), 188.

[19] R. Kumar, ed., *Women and Sexuality*, 192.

[20] R. Kumar, ed., *Women and Sexuality*, 196.

agents of HIV/AIDS infection. A significant number of them are already suffering from such infection. According to a study made by the National Aids Control Organization (NACO) in the 1990s about 3,500,000 people in India live with the virus. Of these 350,000 people are estimated to be advanced cases. However, during the same period the NACO was able to track down only 13,867 cases through its 141 blood testing laboratories. A spokesperson of the NACO affirms that this figure represents only a fraction of the infected.[21] And it is true. For a current survey brings to light some startling facts in Andhra Pradesh. 2.3 per cent of its population have AIDS while the national ratio is one per cent, i.e., ten million. The district of Guntur alone accounts for 4 per cent of the affected population. It is estimated that in the state where on an average, 1,600,000 deliveries are expected every year, at least 33,000 pregnant women turn out to be HIV positive. Among the sex workers it is 27 per cent.[22]

The level of HIV infection among women is a matter of serious concern. The rate of infection in this group is an indication of the percolation of the virus in the general population. Infected women naturally give birth to HIV positive children. Most studies confirm that physiologically a woman stands a far greater risk of contracting this deadly virus from a man than the other way round.[23] Innocent housewives acquire it from their husbands who have extra marital sex. Among the other worst affected states are Maharshtra, Tamil Nadu, Karnataka, Manipur and Nagaland where the virus has spilled over to the common population making it a national health catastrophe. In the rest of the country the infection is confined to the high-risk groups namely, commercial sex workers and intravenous drug users. Some time ago the detection of AIDS in six prostitutes in Chennai and Pyari Bai, a 24-year old prostitute in Kolkata, and 59 cases of AIDS so far spotted in the country, though confined to prostitutes, sent shock wave

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[21] Rashmi Saksena, "Time Bomb," *The Week*, Dec. 10, 2000, p. 18.

[22] W. Chandrakant, "High Incidence of HIV Positive Cases in Andhra Pradesh Causes Concern," *The Hindu*, Sept. 5, 2002, p. 6.

[23] Shalini D'Souza, "Prostitution and Aids," *Social Action* 40 (1990), 409-40.

among the people.[24] A recent survey conducted by the Society for Rural Development and Protection of Environment (SRDPE), an NGO in the urban slums around Theni district in Tamil Nadu reveals that the HIV/AIDS pandemic has affected even many of the womenfolk including children besides many male heads of families.[25]

ii) Mental Health

Health is a dynamic quality and never a static state. A person does not just get well or keep well. There are many degrees or levels of well-being just as there are degrees of illness. Nor is well-being simply absence of disease. While people often lack symptoms, they still get bored, depressed and become tense, anxious and despaired of life. These emotional states often influence our physical health. For health is a quality that involves also the psychological dimension of our life. The same feelings may also lead to addiction to smoking and alcohol. But these symptoms and behaviours represent only the tip of the iceberg. Deep within the person are the surface needs such as recognition and acceptance by others, a stimulation environment, caring and affection, and self-confidence. In several cases diseases and symptoms are not the real problem. They are body-mind's attempt to solve a problem – a message from the subconscious to the conscious level. Therefore, though, elimination of the symptoms of a disease no doubt is important, that alone is not enough for the health of the person. It is very necessary to delve into the surface and detect the real needs. The search for this surface needs points to mental/emotional health. A brief treatment of women's mental health is certainly in place here. A couple of incidents may highlight the importance of providing mental health facilities to women.

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[24] R. Kumar, *Women and Sexuality*, 198.

[25] Express News Service, "'Handful Rice Scheme' Aids for Families of HIV/AIDS Victims in Theni District," *The New Indian Express*, June 14, 2002, p. 3.

a) Rape and Trauma

In Mumbai on Aug. 15, 2002, the Nation's independence day, one Salim Khan raped a 12-year old girl in a suburban train between Churchgate and Borivili while seven passengers in the compartment were mere spectators. Her pathetic scream fell on deaf ears. In Delhi on Aug. 19, 2002 a 32-year old woman was dragged into a car by four men who gangraped her and then dumped her in an isolated spot. A day later another girl student was forced into a car and gangraped. In Chennai a college girl student who went to the Pulianthope police station to lodge a complaint was illegally detained and sexually molested by the policemen on duty.[26] The relentless list goes endlessly.

A study by WHO reveals that every 54 minutes a woman is raped in India. But the statistics given by the Centre for Development of Women Studies (CDWS) in India is more disturbing. It says that 42 women are raped every day in India, one in every thirty-five minutes. Accurate statistics would curdle our blood, were it not for the fact that a large number of such cases go unreported. A field study conducted in 2000 by the Chandigarh based think tank, Institute of Development and Communication (IDC) on atrocities against women found that the chasm between the reported and the unreported cases is unbridgeable and unimaginable – 1:68. For every FIR filed for molestation, 374 remain unreported. This is an indication that that the female identity is still viewed through the Stone Age prism. Lodging complaints about such cases is misconstrued as unbecoming of the female character. According to the National Crime Reports Bureau the volume of rape cases in India swelled from 15,468 in 1999 to 16496 in 2000, a jump of 6.6 per cent. That is something alarming given the fact that only a fraction of the incidents are reported. The National Commission for Women that registers complaints of sexual crimes against women every day, received between April 2001 and March 2002, 741 complaints from Delhi, 1,748 from Uttar Pradesh.[27] Other states with unsafe cities are Andhra Pradesh,

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[26] S. Vasudev and M. Renuka, "Rape!," *India Today*, Sept. 9, 2002, p. 50, 54.

[27] S. Vasudev and M. Renuka, "Rape!," 52-53.

Bihar, Madhya Pradesh, Maharastra, Rajasthan, Tamil Nadu and West Bengal.[28]

This horrendous crime not only rips open the heart of the victim but also leaves in her an unfathomable trauma. She feels raped every time the incident comes back to her mind. This secondary victimisation, the term used for post-rape trauma, often rubs salt into her emotional wounds. Neena Bohra, head of psychiatry at Delhi's Ram Manohar Lohia Hospital explains that numbness, denial, diffidence, complete disinterest in relationships, general distrust of men and sometimes total withdrawal from life resulting in serious depression and despair are just a few ill effects that a rape victim suffers.[29] Alienation by other women, neighbours and even by her own parents torments her. She confines herself to the four wall of her house. Ineffable are the feelings of such a woman. She is completely broken within. She feels that her inner self is deeply wounded, dignity disfigured, body desecrated, mind shattered and all hope of future dashed. Feelings of loss of self-esteem and self-image isolate her and drive her to the point of utter despair which not infrequently ends up in taking her own life. This is a serious assault on the mental frame of the woman calling into question the purpose of her very existence.

b) Prostitution and Stigma

Prostitution besides spreading many diseases has also an adverse effect on the mental health of the woman. Society looks down upon a prostitute and finds it degrading for a woman to eke out her living by satisfying the basic instincts of different men. A prostitute is denied the rights of a person, and she sums up all the forms of slavery at once – economic, familial, social, political etc. She develops fear psychosis since she is scared of being raided by policemen and gundas who torture her, easily extort her hard-earned meagre income and forcibly separate her children from her. She is despondent because of her ignoble profession. So these sex workers shun the public and avoid facing the society for fear of

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[28] R. Kumar, *Women and Sexuality*, 226.

[29] S. Vasudev and M. Renuka, "Rape!," 54.

their identity being revealed and rejected by the society. Because of the social stigma of being a flesh trader she loses all social recognition and acceptability which are the surface needs of any human person for a healthy life and full flourishing. This fearful life causes many psychological problems too.[30] Her children suffer from infectious diseases and the mother finds it difficult to take them to the hospital or put them in the school. Being a child of a prostitute finding a marriage partner turns out to be only a wishful thinking. All these familial and social factors mount up stress and strain within the prostitutes pushing them to depression and despair. In short, though they may earn their livelihood and even though they may be free from any infection, they do not have the joy and happiness of a normal human being. They are deprived of their legitimate and ordinary joy of life because of their profession and social rejection. Their mental turmoil keeps them mentally/emotionally sick. Consequently their social well-being is also in question. Who will erase this social stigma of these women who are driven to such kind of profession because of our unjust social structure, and bring them joy and peace of mind which alone can guarantee their human well being?

III OBLIGATIONS OF POLITICAL AND CIVIL SOCIETY

i) Provision of Essentials

Life is a loving gift of God to humanity. Health is his blessing. Humans as stewards have the obligation to preserve the precious life. This duty reversely involves a certain right to the means of preserving a healthy life. The UN's Universal Declaration of Human Rights also firmly affirms in article 25 that every human person does have a fundamental right to health.[31] Not the least of those who have joined in the affirmation of the right to health care is the Church. John XXIII was the first Pope to proclaim very explicitly and convincingly the right of the human person to health

[30] Amla Rama Rao, "The Health Status of the Prostitutes and Their Children," *Social Welfare* 37 (June 1990), 22.

[31] B. M. Ashley and K.D. O'Rourke, *Health Care Ethics*, 121.

care. "Man (human person) has the right to live. He (she) has the right to ... the means necessary for the proper development of life, particularly *food, ... medical care....*"[32] Eventually successive Popes laid due stress on their predecessor's teaching regarding health care.

One of the essentials of healthy life is food. It is unbelievable that people die of malnutrition and starvation in a country which has made a giant leap in Green Revolution already in 1980s. Our granaries are full. Yet the most needy people die of starvation and malnutrition. For example, in Maharashtra the districts of Dhule, Thane, Nandurbar, Amravati, Garhchiroli and Chandrapur account for a great number of grade IV malnutrition and consequently for the loss of countless lives of pregnant women and children. It is noteworthy that these districts have many Tribal hamlets. Two things have to be borne in mind here. First, according to the newspaper reports 740 quintals of wheat were supplied to Chikhaldara taluk for distribution for a month but only 140 quintals were lifted. Where were the rest 600 quintals diverted to? Likewise, though 370 quintals of rice were supplied to the same area, only 67 quintals were lifted. Who appropriated the balance? Certainly not the poor ordinary people. Second, even if food is locally available the Tribals and Adivasis are not able to afford it.[33] These facts prove the lacunae in the government's public distribution system. Governments have to monitor and revise their public distribution policy and empower the deserted and forgotten people to buy the essential commodities at an affordable price. Government must know that as it is its duty to store essential commodities of life, so has it also an obligation and a time to empty the storehouses to save the lives of the oppressed people who no fault of their own are deprived of the means to livelihood. It is abominable to let the stock rot and stink or to let the rats gorge on the grains when the marginalised people are famished with hunger. Not only that, the government also has to empower these

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[32] John XXXIII, *Peace on Earth* (encyclical letter), in *The Papal Encyclicals 1958-1981*, ed. (C. Carlen, Wilmington, Delaware: McGrath Publishing Co., 1981), no. 11. (Parentheses and emphases mine.)

[33] D. Bunsha, "The Excluded People," 48.

people, especially the malnourished pregnant women to purchase the commodities at an affordable price by subsidising the food grains and giving them some work to earn. In this respect the recent upward revision of the ration goods (e.g. rice, maize flour, sugar) by the Tamil Nadu Government is not in an any way in the interest of the poorest of our people. In our country where more than 45 per cent rural and 30 per cent urban population live below the poverty line nutritional counselling is of immense value to prevent unfortunate consequences of malnutrition during pregnancy.

ii) Basic Medical Care

The health of the people who cannot get it on their own is the responsibility of the state.[34] The political society has to organise the programmes that are necessary for "directing, stimulating, co-ordinating and supplying the poor with the essentials of life."[35] The biggest challenge of our time is the development of an affordable, accessible and sustainable health care delivery system of standard quality to meet the health needs of our people. The most vulnerable and high risk groups in terms of health care are, as seen earlier the millions of pregnant women rural areas, women of child-bearing age and children under five years of age who are affected by, besides malnutrition, multiple diseases that are preventable and treatable.

At present in India, there are sufficient agencies – both government and private – involved in rendering medical care. But they are all confined to cities and towns. There are hospitals in India excelling in standards any hospital in the West. There are expert surgeons and physicians in India. But the most unfortunate thing is, the services of these experts have not reached all sections of the population. If the benefit has to reach even the poorest of the poor, who are the most needy persons, our system of medical

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[34] Joseph Boyle, "The Right to Health Care and its Limits," in *Scarce Medical Resources and Justice*, ed., Donald G. McCarthy (Braintree, Massachusetts: Pope John Center, 1987), 23.

[35] PaulVI, *Progress of the People* (encyclical letter), in *The Papal Encyclicals 1958-1981*, ed., C. Carlen (Welmington, Dalaware: McGrath Publishing Co., 1981), no. 23.

delivery has to change. The services of the doctors are not freely available in rural areas for obvious reasons. Therefore government has to chalk out the health care policy based on the harsh realities and needs faced by the millions and millions of rural women of all social denominations. New primary health care centres (PHCs) should be opened within reachable distance at an affordable bus fare and all PHCs must be properly equipped with the necessary medicines and trained personnel. Even in Tamil Nadu there are many PHCs that are practically "unstaffed" in the sense that the doctor does not stay there any longer than the time required for him to sign the register even though there is a house attached to every PHC. He comes every morning signs the register and gets back to the nearby town where he has his residence and private practice. Government should also encourage private practitioners to render service in the remote rural areas by giving them incentives by way of subsidies like land at actual cost for building clinics, and easy loans for buying the equipment.

Another health area which draws our attention is the prevalence of HIV infection in many states including Tamil Nadu. The increasing risk of mother-to-child-transmission (MTCT) is a serious cause for concern. In this context the prevention of mother-to-child-transmission (PMTCT) programmes assume significance. The pilot study[36] launched by the NACO in 11 centres attached to the obstetrics and gynaecology departments of the six states could be extended to all the district hospitals of the country. The established 11 centres may serve as training and technical expertise centres.

iii) Mental Health Care

Coming to the mental health of women, the silent lambs who bear the brunt of the trauma and stigma are a forgotten lot by the political and civil society. Public opinion is that only morally loose

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[36] The study included HIV group education-cum-counselling sessions with audio-visual aids, test of blood samples for HIV with written informed consent, post-test counselling and administering of azidothymidine (AZT) to all the attending pregnant women. Tamil Nadu is one of the five states, the others being Maharashtra, Manipur, Andhra Pradesh and Karnataka. T.K. Rajalakshmi, "Programmes and Pitfall," *Frontline*, March 20, 2002, p. 88-89.

women get into the profession of prostitution. This is far from true. No woman wants to be sexually exploited nor is prostitution something a woman volunteers to go into. Most of these girls/women are purchased, kidnapped and drawn in through the agency of organised crime or recruited by individuals with the promise of job. But once a woman is trapped in the cogwheel of prostitution, there seems no way out of the cycle of exploitation. Society looks on them with disdain because it has been imbued with the negative understanding of chastity as an object that has to be preserved untainted and undamaged. Often in traditional spirituality chastity has been compared to a crystal or lily. Once a crystal is broken it can never be repaired and restored to its original condition. It loses its value. Once a lily is smothered it ceases to be fragrant. 'Likewise, chastity is lost by prostitution or rape. It cannot be regained. A woman cannot be chaste again. She is doomed.' So goes society's thread of argument.

Such a trend of thought only betrays society's crafty strategy of escapism. By presenting the evil as a moral *issue of chastity*, society is trying to lay the blame squarely at the door of the victims. By so doing it uses the victims as scapegoats to cover up the stark fact that it is more a *moral issue of justice*. In fact from start to finish, in different stages, it is the society that is responsible for the pathetic condition of these victimised women. Trapping young girls on promise of job opportunities and eventually dumping them in brothels which are utterly unhygienic, treating them like commodities and prisoners, unleashing sexual violence on them and intimidating them – if these are not crimes of injustice what else is? This crime of injustice escalates when the same society is expanding its kidnapping and trafficking zones from urban to rural areas particularly to the Dalit and Tribal belts.[37] This is clearly indicative of the attitude of society's outrageous injustice and criminality towards the poor, Tribal and Dalit women. Such wide raging established immoral institutions dehumanising the socially deprived women are unimaginable without the wider network operating among the dons, politicians, police and government.

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[37] P. Kapur, *Empowering the Indian Women*, 101.

Add to these the regular visitors to the brothels. Society is therefore out and out the agent and promoter of the evil which is an issue of justice, and the helpless women are only victims.

Obviously then society needs an attitudinal change. It has to open its eyes to the mental agony of these women, its mind to new ways of thinking and its arms to these victims living in exile to receive and support them. The onus of rehabilitating the victims lies primarily with the government. Perpetrators of such sex crimes should be brought before the court and everything should be done so that justice is established. This will kindle the trust of the victims in the society and the government. It will also encourage other women to step out of their forced exile and testify before the court the injustice meted out to them in the dark. Job opportunities should be created with priority for these women, and an atmosphere provided which will prevent relapse. Court environments should be improved by making the inquiry procedure more human and supportive of these victims. Though in-camera trials are now obligatory and only the people and officers immediately connected are let in, trials are not that easy by any standard. For there is no provision in our legal system to make the presence of a woman public prosecutor mandatory. On grounds of human right such provisions are offered in the USA for cases involving women. Why not our judiciary respecting the right of these victims provide them with the choice of a woman prosecutor and draw a code of conduct for the male defence lawyers cross-examining these faceless women? For the weaker they are the more support from every quarter has to be given them. NGOs especially women movements should contact these affected women and make good and free counselling services available to them. This programme will have a tonic effect in bringing about the much needed emotional healing. It will also inspire the victims with new hope and vision of life. In collaboration with the government they can bring the necessary health care and medical services for their physical well being too.

Conclusion

In fine we are of the opinion that as responsible citizens, it is our collective responsibility to provide all types help to these victims of our society. Governments – central and state – have to take a lion's share of the blame for such tragic situations. A country

that is willing to spend over Rs 76,000 crores for its defence, allocates just one percent of that amount for its centrally funded public health programmes. Saving people from war when there is no war or from foreign enemies but letting the people die in thousands under its very nose, of malnutrition, starvation and basic health care for the neediest section of its citizens is like straining out the gnat but swallowing the camel. Governments need to set their priorities first and execute them with strong determination. Until then the basic health care for the weakest of our women will be only a pie in the sky.

The Church too must play an important role to promote this ministry and bring these women back to the main stream of social life where they can bloom again. The visible oppression of a large section of our women population is a sign of the time. Christians' attitude to this reality should be shaped by the attitude of Jesus to the woman caught in adultery (Jn 8:1-11). The boundless compassion, unconditional forgiveness and total acceptance of Jesus gave the woman, who was at death's door because of the hardness of the pharisaic society, a new lease of life and brought her back to the main stream of life. Mary Magdalene, a strumpet and sinner (Lk 8:3), as tradition has it, was not only made clean but also elevated as the first apostle to announce the good news of the risen Lord (Jn 20:17-18). Special care of the children of the prostitutes will be a remarkable service to the future generation of India. Institutions run by the NGOs deny their services to these children citing their policy of admitting to their foster homes only destitute children. So the children of the prostitutes are counted out. Interventional strategies for children of different situations – the destitute, street, wandering and working children – have been often discussed but rarely was a word mentioned about the children of the prostitutes. As a matter of fact they too can be called destitute. For they lack the love, warmth and tender care of a mother. Left uncared for, they run errands for their mothers' customers and slowly slip into the same trap. The Church can start centres for the care and development of these children which will ensure a bright future for them in particular and to the society at large.