ORIGINAL RESEARCH

Interplay of Gender Inequities, Poverty and Caste: Implications for Health of Women in the Cashew Industry of Kerala

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Abstract

Despite Kerala's remarkable achievements in the social sector, improvements in quality of life are not distributed uniformly. Exploration of the life of cashew processing women workers indicates high levels of illiteracy, poverty, morbidity, fertility, gender based violence, caste based inequities, and lack of access to health care. To improve the health conditions of women, social and structural factors determining the health of women have to be addressed. Strengthening the public provisions of health and social services is a necessary prerequisite for improving the quality of health care and life. Yet, neoliberal initiatives underway in Kerala State will further endanger the already weakened public health systems.

Introduction

Kerala's remarkable achievements in the field of health and education have been widely acclaimed in the world of academia as well as in policy-making circles. Kerala is India's most literate state; this is true for both men and women. Nearly 90% of women receive some education, in contrast to 54% of all Indian women. The sociopolitical process including the social reform and the communist movements of Kerala and success of the State in providing education and health care has not only helped curb population overexpansion and reduce infant mortality, but has also improved life expectancy. Statistics on health and longevity compare favorably with those of many wealthy developed nations. Likewise the rate of female infanticide is low in comparison with other Indian states.

Yet, despite these achievements in the broader socio-economic context, a array of studies have highlighted inequities and differentials in health indicators and quality of life between genders, social classes, castes and different regions[1-4]. The inefficiency of the public health service system in tackling the problems of communicable disease also adds to the public health challenges[5].

The enhanced status of women in Kerala's development paradigm is reflected in higher levels of sex ratio, life expectancy, education and politicization. But it would be erroneous to assume that there is no discrimination against women[3,4].. With no change in the patriarchal structure of family and society, married women remain victims of gender discrimination, subjected to physical torture and mental harassment from their men. Women suffer from the lack of autonomy and empowerment, needing permission from their husbands to go to the market or to visit friends or relatives. This is reflected in high rates of depressive illness. According to recent data, the suicide rate in Kerala is at least twice the national average, linked to the mental ill health among women and the growth of dowry-related crimes. It is instructive to review the research over several decades identifying the social origins of illnesses which include class structure, gender relations, caste status, ethnicity, labor processes and the political milieu. Additionally, there is a need to look beyond biomedical discourses in planning to improve the

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health of the community[6-11]. Yet there is a conceptual lacuna in relating health and socioeconomic inequities to policies, programs, research and collection of vital statistics[12-14]. The current socio-political trends arising out of the neoliberal policies including increasing informal sector employment, retreat of the state from the provision of social services, and weakening of the labor unions further widen the inequities and endangers the interests of the poor, especially women[15,16]. The injustice for workers such as low wages[17] and the interlocking effect of multiple oppressions at workplace (including gender oppression) affect the health of women workers[18]. Gender specific inequities often deny them the basic human needs of physical and psychological health[19].

The bulk of women in the work place are employed in traditional industries, among which cashew processing and the making of coir[1] and beedi[2] are the most prominent. Our study among the cashew-processing women workers of Kilikoolloor village, in the Kollam district of Kerala, was designed to explore the unequal power relations and multiple faces of discrimination in various domains, including health and well being.

Methods:

Setting: The Cashew Industry in Kerala

Cashew, a tropical fruit, is grown mainly for the edible kernel of the nut and phenolic oil in the shell lining. Cashew processing is a traditional export-oriented labor-intensive industry with limited use of technology; approximately 95% of cashew workers are women[20]. Work is divided among gender lines. Women perform manual tasks such as shelling, peeling, and grading. These tasks are performed while squatting/sitting on the floor. Men are responsible for roasting and work in the heating and cooling sections which require some technical expertise.

The industry has been dominated by private entrepreneurs. A majority of the firms are located in shacks and the conditions of work are appallingly poor. Increasing levels of exploitation in the private firms, inefficiency of public sector agencies and health care institutions and discriminatory practices at work and at home, coupled with the lack of adequate political support, all create an environment in which the women workers struggle to maintain mental and physical health, or - more accurately - fall ill frequently.

Male factory workers are generally salaried employees who are paid monthly and receive a certain amount of compensation when factories close seasonally (as when raw nuts are unavailable). Women cashew workers are paid by the piece and generally receive nothing when a factory closes for a period of time.

Sample of work-factories

For the study of work organization, a 50% sample of the 15 cashew factories in the village was selected. This included eight factories of which six were private, and one each were public and co-operative sector firms.

Data collection among workers

A variety of quantitative and qualitative methods were used to elicit data. In a baseline survey, a 20% sample of households (n=396) was selected randomly. Of this sample, only 350 households (having 460 workers) was surveyed; reasons for non-inclusion were: retirement from work, shifting location or change of employment. In the baseline survey, questions were mainly focused on social class and caste backgrounds, demographics, type of work and membership in the trade union.

Subsequently, 50% of the households in the baseline survey (175 households with 245 workers) were selected for an in-depth study by choosing alternate households. Measures including in-depth interviews, participant observation, focus group discussions and case reports were used to gather information. The in-depth interviews highlighted perceived health problems, health care utilization, fertility and child mortality experiences,

[1] Coir: Extracts from the fibrous husk of a coconut yield commercial coir products such as rugs, doormats and other floor coverings, as well as fabrics for use in soil stabilization and erosion control.

[2] Beedi-making: workers' cooperatives producing hand-rolled cigarettes.

employment details, gender inequities and other oppressive relations at work and at home. Focus group discussions and case reports elicited information on various dimensions of gender and poverty related inequities, impediments in access to quality health care and survival strategies.

The fieldwork for the study was conducted over 14 months from 1996 to 1997 in two phases.

Results

Self reported health problems

Back and body pain, dermatitis, and leucorrhoea (excessive white discharge from the vagina) were the most commonly reported problems (See Table 1). The higher levels of musculo-skeletal problems were likely due to the prolonged sitting in crouched position. The direct contact with corrosive nutshell liquid contributed to dermatitis on fingers and hands; 95% shellers were affected. One of the young shellers pointed out, "*I feel ashamed of going out because of the burns, scars and black stains in the hand. Always I fold my fingers to hide it*." Additional problems included dizziness, general malaise (12%) and acid peptic symptoms such as abdominal pain and gas (10%), which the women often related to lack of food.

Table 1:
Distribution of self reported health problems of the women workers during the day of interview

Disorders		**No. of workers**	**Percent***
Musculo Skeletal	Back pain	223	90.0
	Body pain	195	79.6
	Leg & hand pain	23	9.4
	Joint pain	67	27.3
	Neck pain	8	3.3
Respiratory	Asthma	31	12.7
	Sneezing	15	6.1
	Cough	8	3.2
	Tuberculosis	2	0.8
	Tuberculosis (healed)	3	1.2
Other	Dermatitis	200	81.6
	Headache	94	38.3
	Diminished vision	15	6.1
	Abd.pain & Gas (APD)	24	9.7
	Giddiness & general malaise	30	12.2
	Fever	19	7.8
	Total no. of workers	245	

*Percent of the total number of 245 workers

Reproductive health problems

A significant proportion of the women suffered from reproductive health problems including miscarriages and uterine prolapse (see Table2). It is pertinent to note that 72% of the workers, who had uterine prolapse (18) and miscarriages(40) worked in the shelling section where they are required to squat for prolonged periods. Many of the women related miscarriages to overwork, lack of food, socio-economic insecurities and gender based violence including lack of emotional support from men. The poor facilities for care and stressful

relationships at the work place and home, could be seen as the social factors contributing to high levels of reproductive health morbidity. One landless woman worker reported,

"*the burden of work at home and factory since 4 o'clock in the morning, especially the factory work in squatting posture led to severe back pain and malaise during pregnancy.. Besides this, beatings and abuse from my husband is part of my life since the third day of marriage. All these and lack of adequate food might have contributed to the two abortions within two years of marriage."*

According to another woman,

"*perhaps my overwork in squatting posture might have led to bleeding and subsequent abortion. Since I did not take good food and rest after the first abortion, my second and third pregnancy resulted in miscarriage. My husband doesn't beat me but he doesn't take care of home*."

Thus, the patterns of disease distribution are closely related with occupation and poverty. This is illustrative of the linkages between socio-economic circumstances, impoverishment and ill health.

Table 2: Distribution of perceived reproductive health problems of the women workers during the day of interview

Reproductive health problems	No. of workers	Percent*
Uterine prolapse	18	7.3
Hysterectomy done due to severe bleeding	10	4.0
Irregular bleeding	10	4.0
Lucorrhoea	117	47.8
Yellow vaginal discharge	21	8.6
Miscarriages (in whole life period)	40	16.3
Cancer uterus	1	0.4

Percent of the total number of 245 workers

Among married women the average number of births (2.9 per woman) was higher than state averages for total fertility (1.96)[21]; 23% of the married women reported losing one or more children before the child's seventh birthday.

Work and social conditions

Cashew processing is characterized by high levels of underemployment and informal work (employment on a casual or temporary basis by private firms). The underemployment rate is much higher in the public sector, which may provide a few weeks of work during the year compared to the private and cooperative sectors which may provide several months of work

Reflecting the gender division of labor, the women receive their wages at a piece rate. Men get a monthly salary which enables them to claim 1/3rd of the salary during no work seasons; this is denied to the women workers. The piece-rate wage system for women is an obvious means of exploitation as it drives women to work harder even skipping breaks for food or rest. The casual laborers are paid only at a consolidated rate which is less than half the minimum wage. Other than wages, the welfare benefits for the permanent workers were largely limited to gratuity and provident fund (GPF), cashew workers relief welfare fund, health care facilities at Employees State Insurance scheme (ESI) outlets and a very nominal amount of pension. For GPF, workers have to pay a contribution of 8.3% of their weekly wages and for ESI, it was

1.5%. Though the deductions are regular from the wages, nonpayment/underpayment of gratuity and provident funds, ESI contributions, dearness allowance and denial of health care - including maternity benefits - were other forms of oppression in the workplace. As many as 85% of workers in the private firms revealed that they did not get the provident fund credit card, though money had been deducted from their wages for years. Thus, their status was more like that of the workers in the unorganized/informal sector

The physical conditions of the work site were deplorable and included unhygienic floors, dirty work surroundings, stinking latrines and occasional accidents because of a falling and dilapidated roofs. None of the eight sample 'factories' including the public and co-operative sectors provided adequate facilities such as sufficient space, light, fans, crèche (day nursery), drinking water and canteen as per the norms of the Factories Act, 1949.

Shelling was the most crowded section of the workplace. Here women squat in rows on an uneven floor filled with burned nutshells and dust. In these cramped rooms women squat tightly packed together. Their backs touch the backs of the women behind them and they rub elbows with the women sitting to their sides. Strict surveillance is maintained at the work sheds which are supervised by men. The women are not allowed to pay attention to others, speak, nor stretch their back during work. They seldom go to the toilet because of constant monitoring. Their movements and interactions during work invite disciplinary actions including angry scolding.

Given the oppressive conditions at work, the trade union could have provided valuable support but most women felt highly dissatisfied with the union's lack of support. The union's lack of vision and strategies to empower women undercuts the much acclaimed politicization of Kerala's women and reduces their collective bargaining power as well. . As one of the workers pointed out "*I have united the workers against the denial of welfare benefits, resisting the scandals of immorality and threat of dismissal from the employers. But the trade union did not want us in leading roles but just for filling gaps in processions".*

Intrahousehold inequalities

Apart from the exploitative relationships at the work place, the women were subjected to the enduring stronghold of dominant patriarchal structures in various domains. More than 80% of the women did not receive any kind of domestic help from their husbands while discrimination in food allocation practices limited their access to food. According to the mother of a 12 year old girl,

> "*Often I make compromises while sharing food and give a lesser amount to my daughter and I consume even less to serve the needs of my 16 year old son and my husband*".

Resource control and decision making

Despite bearing the burden of hard work, even skipping food in order to save time and money, women workers exert very little control over their income; 23% of the women in the study were not allowed to spend any money on their own and 41% were forced to give at least a part of their weekly wages to men. Women spent >90% of their income for household expenditures highlighting their role as substantive contributors to the household. Yet this was not often reflected in their role in decision making processes; 67% of them reported that men make the important decisions. Also, the men spent only 40-60% of their income for family expenses and for those men who consume alcohol the percentage was even less (20-40%).

Mental stress and violence

At home, 35% of the women were subjected to physical beatings by their husbands. Lack of trust and desertion by men, violence during sexual relations and various other means of domination and control were pervasive in their lives.

At work, strict surveillance including use of language itself as a means of coercion, constraint, intimidation and abuse was a major source of mental stress. Verbal abuse (96%), indecent comments and gaze (69%) on the part of the management were not uncommon. Mostly, the youngsters bear the brunt of it. A 16 year old girl recalled her experience. The supervisor of the firm pulled her hands making a vulgar comment "*Why is your chest so swollen*?" Humiliated and depressed the girl quit the job. But

the next day her friend retorted to the supervisor, "*Will you behave the same way to your children*?" only to get abuse and a drastic low output while weighing her work for the day. Taking advantage of poor women's desire for better life it appears that young managers at the workplace may sexually exploit them by offering small favors in return. The cultural inhibition and imposed fear about morality often impair the women's resistance.

Often this violence, compounded by lack of access to food, makes the women mentally stressed. As pointed out by a 40 year old landless woman.

> *"I leave for work early in the morning with an empty stomach to reach the worksite by 8 am. If I am late even by minutes that day's job is forgone. My husband drinks and beats me up almost all the nights. Any lack of resources including food at home ends up in violent beatings. During pregnancy (twin), I was hospitalised for many days following a kick by him. I bear all the hardships for the sake of my children. Many a times I thought of killing myself".*

Dowry and land ownership

In recent decades, commercialisation of marriage has brought many new variants to the dowry, the contributions in cash or kind from the bride's family to the groom during marriage. Currently, in the study area, the dowry includes cash (villagers call it 'pocket money' since legally cash cannot be given to the groom as part of dowry), land, golden ornaments, expensive furniture and household appliances.

Lack of adequate assets to provide a dowry often leaves women unmarried. A 28 year old woman lamented

> "I *started cashew work at 14 years and earned some money for dowry without spending much even for food. But the groom's demand was much higher than my earnings. Where can I go for the money? My parents are dead*".

To provide for a dowry workers were often forced to sell their limited landed property or use a form of "voluntary retirement from permanent employment" to obtain lump sum monetary benefits, specifically payments in lieu of gratuity and provident funds.

Although 33% of women own a small piece of land in their names it is not necessarily a symbol of their economic autonomy. Rather, they acquired it as a prerequisite for marriage because land transaction to the groom as part of dowry is illegal. Being recorded as 'owners' in the land registers does not necessarily give women control; decisions about land use/sale are made by men. In the words of a 26 year old woman, "*Now I stay with my parents. My husband sent me back to my natal home because I haven't signed the documents to sell the land in my name which I got as part of dowry*".

Intersection of poverty, caste and gender

The living conditions of the workers were appallingly poor (Table 3). They have limited landholdings, impoverished housing, and lack of access to adequate water, electricity and toilet facilities. The educational levels of workers were disquieting. Twenty-two percent of them had not attended school. Importantly, illiteracy was much high (nearly 50%); the majority of the women who had attended primary school were still not able to read and write. (Table 4)

Seventy percent of the households failed to provide 2 square meals a day all year round for all its members. It is the women who go hungry more frequently. The quality of available food is questionable; milk, eggs, meat, fish, and fruits are often not included in the menu. Despite stretching themselves beyond their physical capability for survival, the women and their families simply do not have sufficient food to satisfy their hunger. Analysis by caste revealed that the Scheduled castes were more deprived in terms of living conditions, literacy and lack of access to adequate food. The second most deprived group was the Muslims.

Access to health care services and their utilization

The health care institutions available for the workers included one ESI dispensary, one ayurveda dispensary for holistic healthcare, a mini primary health center (PHC) with the services of one doctor for a rural population of 30,000, and six sub-centers with the services of one male and female health worker for a population of 5000; these are all in the

Table 3:
Land ownership pattern and availability of household facilities among the workers
(Land in cents. 100cents =1.5 hectare)

Land ownership	No. of households	**Types of house**	No. of households
Landless	18(3.9%)	Tiled	269(58.5%)
1-10	396(86.1%)	Thatched	108(23.5%)
11-20	37(8%)	Tin sheeted	54(11.7%)
21-30	6(1.3%)	Terrace	29(6.3%)
31&above	3(0.7%)	-	-
Total	460(100%)	Total	460(100%)
Electricity		**Latrine**	
Yes	359(78%)	Closet	69(15%)
No	101(22%)	Borehole	308(67%)
		No	83(18%)
Total	460(100%)	460(100%)	460(100%)

Table 4: *Caste wide distribution of education of the workers

Caste	**Illiterate (never attended school)**	**Lower primary**	**Upper Primary**	**High School**	**College (plus 2)**	**Total**
Other Backward Castes	39 (18)	72 (33.2)	72 (33.2)	30 (13.8)	4 (1.8)	217 (47.2)
Scheduled Castes	35 (36.5)	26 (27.1)	13 (13.5)	21 (21.8)	1 (1.0)	96 (20.9)
Muslim	23 (27.7)	23 (27.7)	22 (26.5)	15 (18.1)		83 (18.0)
Nair	5 (8.8)	19 (33.3)	22 (38.6)	11 (19.3)		57 (12.4)
Christian		2 (28.6)	4 (57.1)	1 (14.3)		7 (1.5)
Total	102 (22.2)	142 (30.9)	133 (28.9)	78 (17.0)	5 (1.1)	460 (100)

Figures in the parenthesis indicate percent to total 460 workers in the baseline survey

***Caste** plays a crucial role in the socioeconomic life of the community where the lower castes are often more deprived. In the Hindu caste hierarchy, the Upper Caste Hindus like Nairs constitute the top followed by Other Backward Castes like Ezhavas at the intermediary level, and Scheduled Castes like Kurava, Paraya at the bottom. In general, the Scheduled castes are the most deprived in terms of quality of life including education, health, employment, income and limited access to power structure. Historically, the Upper castes dominated the social and political power structure treating other lower caste people like slaves without many human rights and schedules castes bear the brunt of it. Though the degree and intensity of discrimination has decreased over time , often the low caste status makes major impediments to the schedules caste's vertical mobility in the social life,**.** In the present study the caste distribution is Schedules castes 21%, Other Backward castes 47%, Upper castes (Nairs) 12%, Muslims 18% and Christians 2%.

public sector. The private sector institutions included a few clinics and hospitals with different systems of medicine such as ayurveda and homeopathy.

Data on utilization of health care institutions was collected for two periods: usage within the past two weeks and usage within the 6 months prior to the interview. The differentials in utilization of the two periods studied showed that reliance on the public sector (where 45% of 111 cases sought medical help) was lower than for the private sector (55%) during the two weeks period prior to the interview. This was a period when mostly acute and seasonal ailments were treated. For the 6 months period preceding the interview we focused only on hospitalizations. Here the dependence on public sector institutions was significantly higher (56% of 135 cases) than the private sector (44%).

The striking feature regarding this utilization pattern was that those who suffered from major diseases such as cancer, heart disease, epilepsy and tuberculosis which require prolonged treatment and hospitalization depended more on the public sector. This is in corroboration with earlier findings[22]. In contrast to Kerala's heavy reliance on private sector medical care 61% when household member get sick [23]; 63% of medical care visits among 1200 households in 1996[24], public sector utilization was higher among this group of workers. This could relate to the availability of public sector institutions including the district and ESI hospital (5 kms away) and poor economic background of the workers.

Despite the fact that ESI facilities were specifically meant for the workers, utilization during the two-week period was limited to 35% of 111 cases, mainly reflecting the low quality of services provided. Forty nine percent of the workers reported non availability of drugs at ESI while 55% were dissatisfied with the doctor's attitude. More than 21% reported corruption including under the table payment of health personnel especially doctors. Inconvenient clinic hours were another issue in provision of quality service. Given the limited access coupled with the fact that workers cannot afford to lose a day's wage, many saw illness simply as part of their life.

With respect to the utilization of PHC, 65% of worker households did not depend on it. They preferred the ESI services and complained that the PHC lacked services other than birth control and immunization. An elderly women stated, "I *didn't know that we ought to get medicine for general ailments from the PHC. There we get only family planning services*". This indeed has significant implications at the policy level especially in the context of rising public health problems in the state.

Such experiences often lead people to the private sector. Yet the condition of those who depended on private medical care was even more precarious. This is illustrated by the experience of one of the landless workers. Both her children - aged two and three years - were afflicted with respiratory ailments. She initially tried government services and later shifted to the private sector. According to her, "*I am running from pillar to post to repay the debt Rs 7000 (around US$ 155) incurred for the medical care. Perhaps I will take a voluntary retirement to get the provident fund benefits in lump sum or sell a part from my parents' 2 cents of land. But we all including my husband dwell in a hut on that land*". Likewise an illiterate woman with cervical cancer who was now receiving treatment in the public sector had relied on the private sector initially. She lamented "*delay in diagnosis and a debt of few thousands for treatment in the private sector forced me to resign employment to avail myself of the retirement benefits in a lump sum to repay the debt. Now I am trying to join a private firm on temporary basis. I don't have any security in my life, job, money or even my own health."* The existing health care system, thus, not only provides inadequate health care but often also contributes to mental burdens that affect women's health.

Discussion

This study highlights certain pertinent issues in the context of Kerala's development experiences and the efforts to decentralize health service administration by placing them under local control. Despite better achievements of the state in social development, cashew add to the pockets of poverty and underdevelopment in a way that is similar to other traditional sectors of agriculture, such as coir,

fish[25] and beedi[26]. Apart from simple lack of access to tangible basic services, the poverty of the cashew workers embodies lack of power, isolation, denial of self-identity and a lack of a dignified atmosphere at home and work. A culturally appropriate and feasible multipronged approach, to deal with women's strategic and practical needs, at the policy and local level would empower them to meet the challenges. Ingredients in this multi-pronged approach would include measures for basic provisions of food and shelter, creative adult education efforts with a focus on democratic relations at home and public space for both men and women, and provisions for dignified physical and social environment at work.

All of the experiences related by the workers, their unprecedented illness and subsequent indebtedness as well as their poverty and social insecurities also underscore the need for efficient and quality health care services in the public sector where people especially from the poor social class can meet their perceived needs. In effect, the inefficiency of the government medical care services not only impair the utilization, but also denies women workers their basic right to health care.

Despite investments in the welfare sector, these measures have only scarcely reached those for whom they were primarily initiated. This indicates a crisis of the public sector when, in the process of providing welfare, it fails to compete with the private sector. The latter expands and further adds to exploitation of labor of the poor women without providing them adequate basic welfare measures. In the totality of women's lives, the plural faces of gender inequity raise serious apprehensions regarding not only women's health but also the gender concerns in Kerala's development path.

Further, the recent initiatives in the health sector which enhances the privatization efforts, including public-private joint ventures, raise serious concerns regarding access to health care especially for the poor. Studies in the Indian context illustrate that the hold of private sector on medical care will deny access to the poor as well as endanger primary healthcare[27]. The economic reforms extending the commercialization and commodification of medical services and the breakdown of public health system have left the suffering poor even more deprived[28].

A variety of studies across the globe show the adverse implications of the adjustment programs in the health sector. In countries such as Vietnam, Chile and Mexico the strategy to transform the predominantly publicly funded and publicly managed health care system to a market driven system significantly affected universal coverage, equity, efficiency and quality[29,30]. In the United States, a million people lose their health insurance every year[31]; in 1999, there were 5.9 million mothers without health insurance at high risk that needed preventive and primary care will not be available [32]. As Schuftan[33] argues, privatization accelerates poverty, lowers the access and quality of services for the poor and widens the gap between rich and poor.

Given the sufferings and the inability to meet the health needs of the traditional sector workers including the cashew industry, improving the public sector institutions is a necessary prerequisite for better health, though it is not sufficient. In many of the industrialized countries, 70-90% of the health care expenditure is through the public sector. Importantly, the public expenditure on health in India is only around 1% of Gross Domestic Product, much less than WHO's recommendation of 5%. In most of the Indian states government health expenditure has decreased and in Kerala, it declined to 1.17% in 2001-02 compared to 1.46% of Gross State Domestic Production in 1992-93[34]. This is where the eroding base in Kerala's public health system is most strikingly evidenced. In addition to the rising trend in maternal mortality[35] and infant mortality[36], the state is riddled with resurgence of malaria, onset of newer diseases like dengue, leptospirosis and chikungunya, occasional outbreaks of cholera, poverty deaths and higher levels of suicide, despite the remarkable achievements on record.

Provision of quality health and health care services will be possible only when public health and development policies are strengthened in an egalitarian, gender sensitive and socio-culturally and ecologically appropriate ways. An integrated approach to the provision of public health and

developmental services with active participation from local self-governing institutions, trade unions, and the community, particularly women will be the most meaningful way to promote health. By highlighting these inadequacies, the intention was not to belittle the achievements of Kerala but to delineate the next step for breaking new ground for a more meaningful and comprehensive planning process. This process needs to be more sensitive to the needs of the deprived sections, especially women.

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