HEALTH AND DEVELOPMENT PROGRAMMES IN KARNATAKA: ANALYSIS OF WOMEN'S HEALTH

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Abstract: Health is an essential requirement of every individual and so much so of national and international society. It is an important input in the developmental process. The status of under-nutrition and malnutrition in women and children, by direct intervention (Provision of supplementary nutrition) is not likely to improve unless the dietary practices improve at the household level. Selective supplementary nutrition programme for below poverty lines may be continued. There are large scale variations in health achievements among people in society and with gender inequality in health matters. This paper contributes to a nascent scholarly discussion of women's health status in Karnataka. This study uses data from National Family Health Survey (NFHS)-1&2 Karnataka where detailed information was collected on pregnant women who received antenatal services, women's food consumption, and nutritional status among married women with iron deficiency. Further the study also addresses the Caste wise and Residence wise health status of women in Karnataka.

Keywords: Women, Nutrition Policies, Food Deficiency, Karnataka, NFHS

INTRODUCTION

Since the turn of the nineties, when economic reforms and structural adjustments were initiated in India, the health sector had been experiencing both direct and indirect effects of these reforms. As a direct consequence of neo-liberal policies and SAPs, the government began to retract from its commitment of providing health services and facilities to all its citizens. Real expenditures for what was once internationally acclaimed as an elaborate and well-envisioned public health structure, capable of reaching huge numbers of people, began to reduce steadily. As a direct impact of reforms, the public health expenditure fell from 1.3% of Gross Domestic Product (GDP) as achieved in 1985 to 0.9% of GDP7. This is the lowest in the last two decades, ranking the country as the fifth lowest in the world in terms of public health expenditure. This cut-back is reflected in – widening of disparities relating to survival and health – urban-rural as well as socio-cultural (gender, caste, class) – and slowing down of improvements in the health outcomes such as child mortality, infant mortality, etc. The existing disparities also resonate the manner in which resources have been allocated within the health system. For instance, the ratio of hospital beds to population in rural areas is fifteen times lower than that for urban areas. Similarly, a pregnant woman from the poorest quintile of the population is over six times less likely to be attended by a medically trained person during delivery. In addition, per person government spending on public health in rural areas is seven times lower as compared to the urban areas.

The trend of reduced public investments and expenditures in health care is forcing people to increasingly access healthcare from the private sector. However, while the dominance of the private sector on one hand, is denying access to a large section – particularly the poor, women and other marginalized communities of the society, on the other, it is skewing the balance towards urbanized, tertiary level care with profitability prevailing over equity. It is increasingly pushing the poor to take loans or sell off

their assets to spend on private medical care, which is expensive and not always appropriate or rational. Further, the profit oriented corporate health care services with its urban and elite mindset has not only given rise to unethical practices in terms of irrational diagnostic and screening tests, high curative costs, etc., it has also reduced the concentration of trained medical practitioners in the public sector, especially in rural areas. Both these processes have led to further impoverishment of the poor in general and women in particular. More disturbing is the fact that this trend is in a context where the state spends less than 1% of GDP on health care and the rest is spent by people's own resources. This translates to only 17% of total health expenditure being borne by the government an overwhelming 83% health care expenditure being private. The consequence, of this dismal allocation is a grossly inadequate public health system that is unable to meet health care demands of people and deteriorating quality of services resulting in poor health outcomes. It also makes the health sector in India one of the most privatized in the world.

Good health is an invaluable asset for better economic productivity, both at the individual and national level, but above, all; it is valued by those who own it as a prerequisite for a better quality of life and better standards of living. Sub-populations who are at the highest risk from poor health and its effects on longevity and morbidity are the poor, women, the Scheduled Castes and Scheduled Tribes. The main reasons for the high level of vulnerability of these sub-groups are, first, the inaccessibility of healthcare, and second, their inability to spend on healthcare interventions. Public healthcare systems must, therefore, provide that critical barrier between ill-health and the ones who are most vulnerable, but here too, factors such as financing and efficiency greatly influence the quality and coverage of public healthcare services.

The central budgetary allocation for health as a percentage of the total central budget has been stagnant at 1.3% during the eighties and nineties, while the allocation in the states have declined from 7 to 5.5% for the same period. Both central and state governments have been allocating only one-third of their expenditure on preventive and curative care. Further, out of the total curative care spending, nearly 75% is spent on secondary and tertiary sector hospitals, which are located in the urban areas. The rural areas are often ignored in the process.

REVIEWS

Sinha, R.K. and Singh, S.K. (2003) conducted a study in Bihar by International Institute for Population Sciences, aimed at finding out the community perception towards barriers in adopting a small family and their socio-economic as well as cultural correlates; to assess the views of service providers and program managers towards problems and prospects in effective implementation of population programmes; and to analyze the ongoing IEC programme. Focus group discussions and interviews were conducted for data collection. A three stage random sampling was done, thereby Muzzafarpur, Rohtas, and Kishanganj districts were selected on the basis of family planning performance. Three PHCs were selected from each district on the basis of its performance, and a total of 27 villages were selected from the selected PHCs on the basis of health facilities available. One Medical Officer and One Para-medical staff from each of the 9 selected PHCs, and 45 district level programme managers was selected for the study. Data was collected through focus group discussion and interviews. Irregular supply of contraceptives/medicines and other basic materials required, particularly vaccines, adversely affected the contraceptive promotion and child immunization programme in the state. Poor infrastructure, irregular power supply, poor quality of transport and communication refrained people from utilizing public health facilities. Staff members could not upgrade their knowledge and skills as provisions of in-service training were limited. Lack of accountability of job responsibilities and irregular flow of salary deteriorated effective functioning of the RCH programme. Absence of proper planning and coordination at PHC/CHC hindered programme implementation, and resulted in unmet needs of contraceptives, lower immunization coverage, low level of institutional deliveries, etc. There was hardly any effort made to screen high risk mothers in most of the PHCs/CHCs in Bihar, which adversely affected maternal as well.

Gupta, Arun and Gupta, Y.P. (2003) study was conducted in 49 districts of 25 states and 3 Union Territories (UTs) where district coordinators of BPNI were present. The aim of the study was to assess the status of infant and young child feeding practices in India, and the barriers to optimal breastfeeding practices. For quantitative research, a total of 8953 mothers with children aged 0-3 months, 4-6 months and 6-9 months, were selected. To collect the qualitative data, 142 pregnant women, 134 mothers–in-laws/fathers-in-laws, 135 ANM/AWWs, and 212 mothers of infants 0-6 months were chosen. Information was gathered through interviews and questionnaires. About 45% mothers were in the age group of 21-25 years, 58% belonged to SC/ST/OBC, 37% were illiterate and 82% were not working outside the home. Nearly 28% mothers initiated breastfeeding within one hour, 30% within 1-4 hours, and 42% started breastfeeding after 4 hours or more. About 49% mothers gave pre-lacteal feed to their

babies and these were honey (given by 30%), followed by sugar water (20%), and plain water (13%). Knowledge regarding initiation of breastfeeding within 1 hour was highest in Kerala (81.7%) and lowest in Punjab (1.7%). Data showed that 54% children aged 0-3 months and 26% children aged 4-6 months were exclusively breastfed by their mothers, 43% mothers gave other food and water along with breastfeeding, and 19% mothers gave solid foods to children aged 4-6 months along with breastmilk. The percentage of exclusive breastfeeding (0-6 months) was highest in Manipur i.e. 89.9% and lowest in Himachal Pradesh (3.8%). Only 23% mothers gave bottle feeding. About 32% mothers continued breastfeeding for less than 18 months, 46% mothers continued it for 18-24 months, and 22% continued beyond 2 years. 96.7% women breastfed more than 5 times during the day and all respondents breastfed the child during night also. 70% mothers gave solid/semi-solid food to the children aged 6-9 months and 98.6% mothers continued breastfeeding. In Kerala, complementary feeding (6-9 months) was as high as 95%, and lowest in Tripura 28.6%. Initiation of early breastfeeding was higher among literate mothers (61%) and ST mothers, compared to illiterate mothers (51%) and those who belonged to scheduled castes (SC). 58.2% illiterate mothers gave prelacteal feed to their infants compared to literate mothers (45%). No difference was found in the frequency of breastfeeding between day and night among literate (96%) and illiterate mothers (96%). Mothers aged upto 20 years preferred exclusive breastfeeding compared to mothers aged 21-25 years. Exclusive breastfeeding was higher among illiterate (42.5%) compared to literate mothers (38.4%); and among STs and OBCs compared to SCs. Some of the barriers to optimal feeding practices are the practice of giving pre-lacteal feeds, long working hours in office, lack of knowledge regarding exclusive breastfeeding, and misconception in the mind of some mothers that breastfeeding would reduce their beauty. It was suggested that there is need for skilled counseling by TBAs, AWWs, CHWs on the correct method of breastfeeding; self help groups in villages should be motivated to spread messages on exclusive breastfeeding; and there should be provision for crèches for working women at their workplace. It was recommended that the Government should increase maternity leave from 135 days to 180 days. There should be proper guidelines for implementing the IMS Act; and efforts should be made at the centre and state level to strengthen basic education curriculum on infant and young child feeding in secondary schools, colleges, nursing schools, ICDS system and medical colleges.

National Institute of Nutrition, Hyderabad (2003) carried out a study by National Nutrition Monitoring Bureau (NNMB) in Andhra Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, and West Bengal. Objectives of the study were to assess prevalence of Vitamin A Deficiency (VAD) among pre-school children, and Iodine Deficiency Disorder (IDD) among 6-12 year olds; to estimate haemoglobin level among preschool children, adolescent girls, and pregnant and lactating women; to estimate iodine level in the salt used by house-holds (HHs), and serum Vitamin A level in pre-school children; and to assess awareness about IDA and VAD among women. A total of 75600 HHs from 633 villages were covered. Clinical examination of 71591preschool children was conducted for VAD, and 28437 children aged 6-12 years for IDD. 3291 preschool children, 6616 adolescent girls, 2983 pregnant women, and 3206 lactating mothers were covered for haemoglobin estimation. 5209 salt samples from HHs were tested for iodine content using spot testing kits. Knowledge and practices on VAD and IDA were assessed of 2681 and 2178 mothers of children aged 1-5 years, 2053 pregnant women, and 2213 lactating women. Overall female literacy rate was found to be 51%. It was found that prevalence of Bitot spots among 1-5 year olds ranged from nil in Kerala to a maximum of 1.4% in Madhya Pradesh, followed by 1.3% in Maharashtra, and 1.2% in Andhra Pradesh. Overall prevalence of night blindness was about 0.3% (Cl:0.26-0.34) and that of conjunctival xerosis was 1.8%. Overall prevalence of goiter among 6-12 year olds was about 4%. The proportion was higher than WHO categorization of 5% in the states of Maharashtra (11.9%) and West Bengal (9%). Prevalence of deaf mutism and mental retardation was negligible (0.1% in each district). Spot test revealed that 42% HHs were consuming unionized salt, 31% consumed iodized salt as per recommended level of ≥15 pm, and 27% consumed salt having unsatisfactory level of iodine content (about 7ppm). The lowest mean hemoglobin level was found among pregnant women (9.9g/dl), followed by preschool children (10.3 g/dl), lactating women (10.6 g/dl), and adolescent girls (11.1-11.2 g/dl). Overall prevalence of anemia was found to be 67% among preschool children; 69% among 12-14 year old adolescent girls; 75% among pregnant women; and 78% among lactating women. 41% mothers were aware of night blindness. About 24% respondents listed foods like green leafy vegetables, yellow coloured fruits, animal foods, and nutritious food to be consumed for preventing VAD. It was found that only 13% mothers had received nutrition education on VAD. 33.9% women were aware of anemia. 25.8% women stated dietary inadequacy as one of the causes of anemia, while 3.7% could identify it as iron

deficiency. Extent of coverage for Iron and Folic Acid (IFA) tablets was very low among pre-school children (3.8%) and lactating mothers 12.3%, but higher among pregnant women (62.2%). Those who received ≥90 IFA tablets was very low and ranged from 2% among preschool children to 30% among pregnant women. About 9% pregnant women, 4% lactating women, and 0.3% preschool children reported side effects on consumption of IFA tablets, mostly in the form of vomiting (0.2-4.1%), nausea (0.1-5%) or black stools (0.1-1.2%). Study revealed that risk of developing Bitot spots was twice as high among children of SC/ST communities. Similarly children from HHs without sanitary toilets had higher risk (OR=1.76) than those with sanitary toilets. Risk of developing anemia was twice as high among preschool children belonging to Hindu and Muslim families compared to Christians and those from HHs not having sanitary toilets. Poor outreach of the NNMB programmes resulted in unsatisfactory nutrition education, and covered only 14% of the targeted beneficiaries. There is an urgent need for improving the implementation of national nutrition programmes and strengthening nutrition education.

National Health Policy

The National Health Policy 2001 (Draft) promises to ensure increased access to women to basic health care and commits highest priority to the funding of the identified programmes relating to women's health. During the Ninth Plan period, several new initiatives were taken as part of the Reproductive and Child Health (RCH) Programme (1997), in order to make it broad-based and client-friendly. All the interventions of the erstwhile programme of Child Survival and Safe Motherhood (CSSM) became part of RCH. During this period, the focus shifted from the individualized vertical interventions to a more holistic integrated life-cycle approach with more attention to reproductive health care. This includes access to essential obstetric care during the entire period of pregnancy, provision of emergency obstetric care as close to the community as possible, improving and expanding early and safe abortion services and provision for treatment of Reproductive Tract Infections/Sexually Transmitted Infections (RTI/STI) cases at the sub-district level. Under the Universal Immunisation Programme, launched in 1985-86, which became part of the RCH Programme in 1997, the coverage of Tetanus Toxic Vaccination of pregnant women increased from 40 per cent in 1985-86 to 76.4 per cent in 1996-97 and to 83.4 per cent in 2000-01. The scheme of Training of *Da*is was initiated in 2000-01 in 142 districts in 17 states. An extensive network of 2,935 Community Health Centers (CHCs), 22,975 Primary Health Centers (PHCs) and 1,37,271 village level Sub-Centers was put into operation by the end of the Ninth Plan. The Ninth Plan also envisaged promoting institutional deliveries, both in urban and rural areas. A comparison of National Family Health Survey (NFHS) I and II shows that the institutional deliveries has risen from 26 per cent in 1992-93 to 34 per cent in 1998-99. As a result of the above initiatives, the Crude Birth Rate fell from 29.5 to 26.1 and the Crude Death Rate from 9.8 to 8.7 between 1991 and 1999.

National Nutrition Policy

The National Nutrition Policy (1993) advocates a comprehensive inter-spectral strategy for alleviating all the multi-faceted problems of under/malnutrition and its related deficiencies and diseases so as to achieve an optimal state of nutrition for all sections of society but with a special priority for women, mothers and children who are vulnerable as well as 'at-risk'. Of the two major problems of macro and micro-nutritional deficiencies that the women, mothers and children suffer from, while the former are manifested through chronic energy deficiency (CED), the latter are reflected in Vitamin A, Iron and Iodine deficiencies. The strategies adopted in the Ninth Plan include – screening of all pregnant women and lactating mothers for CED; identifying women with weight below 40 kg and providing adequate ante-natal, intra-partum and neo-natal care under the RCH programme and ensuring they receive food supplementation through the Integrated Child Development Services (ICDS) Scheme. The ICDS, launched in 1975, provides supplementary feeding to bridge the nutritional gaps that exist in respect of children below 6 years and expectant and nursing mothers.

National Nutrition Mission (NNM) which has been set up in 2002 with an overall responsibility of educing/eliminating both macro and micro nutritional deficiencies in the country. As part of the efforts of NNM, a new programme to combat under-nutrition among adolescent girls and expectant and nursing mothers is being launched by the Department of Women and Child Development on pilot basis during 2002-03; covering two most backward districts in each of the major states and most populous districts in rest of the smaller states and UT's. Under this pilot programme, food grains are supplied free of cost through targeted Public Distribution system directly to identified families with under/malnourished persons (Planning Commission 2002-07).

Adolescent Health

Component of adolescent health has been included in ICDS programme in over 2000 ICDS projects since 2000-01 all over the country after initial successful results from 507 experimental projects. Tenth five year plan envisages universalization of Kishori Shakti Yojna (KSY) - KSY a key component of ICDS

scheme which aims at empowerment of adolescent girls, in all ICDS Projects with necessary linkages in other sectors and schemes. Limited numbers; 10% of anganwadis are being covered in 2000 ICDS projects each anganwadi covers 20 adolescent girls between 11-18 years who belong to weaker section families (BPL) and are school drop outs or not enrolled in schools. The present model of adolescent health programme in ICDS needs explicit focus on communication needs of adolescent on vital areas of reproductive health, literacy, behavior change and adoption of healthy life styles apart from vocational skills. The efforts of Anganwadi workers when combined with efforts of ANM's and teachers can enrich the programme outcome and achieve the set goal (NIPCCD 2002).

Besides this, since 2000-01, the Government of India has been providing Additional Central Assistance to the states under the nutrition component of Pradhan Mantri Gramodaya Yojana (PMGY) in an effort to prevent the onset of under-nutrition in the age-group 6-24 months. Supplementary nutrition is also provided to 105 million school-going children under the National Programme of Nutritional Support to Primary Education (also popularly known as Mid-Day Meals Programme).

Karnataka State Integrated Health Policy 2004

(a) Providing integrated and comprehensive primary healthcare (b) Providing a credible and sustainable referral system (c) Establishing equity in delivery of quality healthcare (d) Encouraging greater public private partnership in the provision of quality healthcare in order to better serve the under-served areas. (e) Addressing emerging issues in public health (f) Strengthening health infrastructure (g) Improving access to safe and quality drugs at affordable prices (h) Increasing access to alternative medicine systems

Health Programmes In Karnataka

(a) Task Force on Health and Family Welfare, Karnataka (b) Management of Primary Health Centres by Non Government Organizations and Medical Colleges, Karnataka (c) Decentralized Wastewater Treatment System, Karnataka (d) Telemedicine scheme for cardiac emergencies, Karnataka (e) Smart Card Initiative for Sex Workers, Karnataka (f) Community Health Insurance Programme, Karnataka (g) Arogya Raksha Yojana Health Insurance, Karnataka (h) Yeshasvini health insurance, Karnataka (i) Ensuring traditional birth attendant training includes practical instruction, Karnataka (j) Village Health Committees, Karnataka (k) Scheme for Assistance to Families in Exigency (SAFE), Karnataka. (l) Setting up a Vigilance Cell for the health sector, Karnataka

Antenatal Care

The proportion of pregnant women receiving antenatal care (ANC) increased by about 3 percentage points between two surveys. In urban areas, this proportion has increased much more significantly than in rural areas. The proportion of pregnant women among Scheduled Tribes receiving professional care has declined though there has been an increase among Scheduled Caste women. Antenatal examinations by doctors have also increased (table.1)

Women's Nutrition

The consumption of a varied and nutritious diet is crucial for the health of all people but particularly for women in the reproductive age. For a balanced diet adequate quantities of protein, fat, carbohydrates, minerals and vitamins are required and these are found in meat, fish, egg, milk, pulses, cereals, vegetables and fruit. NFHS-2 data on the consumption pattern among married women (table.2) shows that a majority consume pulses and milk/curd at least once a week. More than 90 per cent eat vegetables once a week and about 54 per cent eat fruit at least once a week. Women in urban areas consume a greater variety of food items is relatively low among SC and ST women. Women with a high standard of living inevitably have the highest consumption of all food items.

The nutritional status of the ever married women is expressed through body mass index (BMI). The BMI is the product of weight in kilograms divided by squared height in meters and expressed as (kg/m2). The cut-off point for height, below which a woman can be identified as nutritionally at risk, is in the range of 140-150 cm. The average height of women in Karnataka is 152 centimeters (one cm taller than the all India average). The mean height for women in Karnataka varies slightly among different groups and only about 10 per cent are less than 145 centimeters in height.

The mean BMI for women in Karnataka is 20 and varies within a small margin of 19-23 in different groups. About 39 per cent of women have a BMI below 18.5 indicating a high prevalence of nutritional deficiency. Nutritional deficiency is higher among women who are from rural areas, illiterate, low income and among SCs and STs (table.3).

CONCLUSION

As a matter of fact at village level, the anganwadi centre has become a pivot of basic health care activities, Contraceptive Counseling and supply, nutrition education and supplementation, as well as pre-school activities.

Table 1: Percentage of pregnant women who received antenatal services by background characteristics

Background Characteristics		NFHS-1				NFHS-2			
		At Home	Outside home		Total	At Home	Outside home		Total
			From Doctor	From other			From Doctor	From other	
Mother's age	<20	17.3	58.6	4.5	80.4	3.4	65.6	13.5	82.5
	20-24	18.7	60.7	5.9	85.3	5.5	72.9	10.0	88.4
Residence	Urban	5.0	77.8	3.9	86.7	1.2	86.7	6.5	94.4
	Rural	24.1	52.0	5.9	82.0	6.4	62.9	13.3	82.6
Caste	SC	24.7	51.7	5.1	80.5	7.1	63.3	12.0	82.4
	ST	20.5	53.6	4.5	78.6	9.9	48.5	13.4	71.8
Total		18.6	59.4	5.4	83.4	4.8	70.3	11.2	86.2

Source: 1. National Family Health Survey-1, Karnataka 1992-93, 2. National Family Health Survey-2, Karnataka 1998-99

Table 2: Women's food consumption by background characteristics (at least once a weak)

Background characteristics		Type of food						
		Milk or Curs	Pulses or beans	Green leafy vegetables	Other Vegetables	Fruits	Eggs	Meat or Chicken or fish
Residence	Urban	85.7	99.2	96.1	96.1	72.2	50.8	44.6
	Rural	70.1	98.3	91.7	89.5	43.8	34.0	28.2
Caste	SC	55.7	97.9	92.2	91.0	39.8	49.4	44.5
	ST	62.7	98.1	90.2	86.6	38.1	37.2	26.6
Total		75.5	98.6	93.3	91.8	53.7	39.9	33.9

Source: NFHS-2, Karnataka 1998-99

Table 3: Nutritional status among ever married women in Karnataka: 1999

Background Characteristics		Mean height (cm)	Percentage below 145 cm	Weight mean body index (MBI)	Percentage below BMI (18.5kg/m)
Residence	Urban	151.8	11.4	22.3	23.8
	Rural	152.1	8.6	19.3	47.0
Caste	SCs	151.5	11.3	19.1	44.2
	STs	151.9	9.4	19.2	49.0
Total		152.0	9.6	20.4	38.8

Source: NFHS-2, Karnataka 1998-99

Table 4: Percentage of married women (15-49 years) with iron deficiency – Karnataka 1999

Background Characteristics		**Any anaemia**	**Mild**	**Moderate**	**Severe**
Age	15-19	50.7	26.8	22.4	1.5
	20-24	45.7	30.8	13.0	1.9
	25-29	40.0	26.1	11.2	2.6
	30-34	40.6	24.5	13.9	2.1
	35-39	40.7	24.8	12.2	2.7
Residence	Urban	35.7	24.5	9.8	1.3
	Rural	46.0	27.8	15.4	2.8
Caste	SCs	46.6	26.0	18.2	2.4
	STs	45.9	27.3	16.4	2.1
Total		42.4	26.7	13.4	2.3

Source: NFHS-2, Karnataka 1998-99

Anganwadi centre also functions as depots for ORS, basic medicines and contraceptives and integrated management of childhood diseases. The Government continues to accord high priority to supplementary nutrition programmes to fight macro and micro-nutrient deficiencies across the life cycle, specifically targeting at the young children of below 24 months, adolescent girls, expectant and nursing mothers. The focus of shifting the priority group below 3 years is welcome approach which is much more realistic as malnutrition morbidity and mortality effects are more severe during the period of vulnerability. Of necessity the contacts with family and parents have to be more frequent and long lasting, for, tracking adolescent girls, pregnant women for adequate nutrition, safe-pregnancy, safe delivery, safe abortions, neonatal care, Postnatal care breast feeding , early childhood care, immunization and integrated management of childhood illness for child protection survival and development. Proportionately more energies and time should be diverted towards iron deficiency and place of delivery with modern techniques and traditional modalities. The supply of quality and nutritional Food for women in rural as well as urban localities are diminishing which the government has to formulate and implementation of the nutritional policies should reach to the deserved rural women.

In Karnataka more concentration should be made by the government towards caste wise nutritional supply of food grains and their access to primary health care centres; whereas higher caste women in rural as well as urban has a better access and facilities towards safe delivery in the hospitals from the concerned doctors whether it is private or governments hospitals. Here we can observe the difference between urban higher caste women and rural lower caste women where higher caste women will have access to each and every facility but there is no proper guidance nor do they have access for better treatment neither in deliveries nor with a nutritional food for their development on par with urban higher caste women.

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