



A STUDY ON THE HEALTH AND NUTRITION EDUCATION FOR WOMEN

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Abstract

Health is a common theme in most cultures. Health plays a vital role in our lives. In context to women's health it is a valuable asset for them. Women have a special role in healthy nutrition of the population. The woman breastfeeds the newborn baby and prepares meals for members of her family. Women employees in food manufacturing, trade, public catering, health care and education account for the majority. In addition, public health depends upon women's understanding of healthy nutrition issues. Women, therefore, play a key role in implementing a healthy nutrition policy, both in the family and in society as a whole. In most Indian household the women of the house eats last, after feeding the whole family. Though there are more illiterate women than men, we find that women learn more quickly and respond more rapidly. So, women need health and nutrition education for the development of society. Health and nutrition education aims at enabling women and men both to gain control over the determinants of health and health behaviour and the condition that affect their health status. This paper analyses the significance of health education to women and thus to society.

Keywords: health, women, nutrition, education.

Introduction

Health is a prerequisite for human development and is an essential component for the wellbeing of the mankind. The common beliefs, customs, practices related to health and disease in turn influence the health of the human beings. Health can be regarded as a state of mental, social and economic wellbeing and not the mere absence of disease. Health is a function, not only of medical care, but also of the overall integrated development of society – cultural, economic, educational, social and political. Therefore, to have sound health, the other depending factors are also to be looked into.

India lives in villages. This adage which emphasizes the agrarian character of the Indian economy and to which such pointed attention was drawn by Mahatma Gandhi continues to be true to this day in spite of the industrial development that has taken place in the last four decades since independence. The industrialization has not made any substantial difference to the proportion of the population that lives in the villages, though the exodus from villages in recent has created problems and added to the urban slums.

Historical Background

The first effort towards the importance of health of people especially women came when the community development programme was launched by the Government of India on 2nd October, 1952. Health is fundamental to the national progress in any sphere. In terms of resources for economic development, nothing can be considered of higher importance than the health of people both male and female which is a measure of their energy and capacity as well as of the potential man hours for productive work in relation to the total number of persons maintained by the nation. For the efficiency of industry and agriculture, the health of the workers is an essential consideration. It has been stated by the Planning Commission.

Health is viewed differently by different people all over the world. There can be no two opinions that health is basic to national progress and in terms of resources for economic development nothing could be of greater significance than the health of women. Poor are the deprived classes but women among the poor are still the more deprived lot in a poor family. Women are the members who receive the least share of all resources – be it food, education or health.

When we talk of development experts and policy maker all over the world agree to the fact that quality of life of the citizens of a country is the major criteria to measure development and not just Gross National Product (GNP) Net National Product (NNP) and other such financial criteria.

Reproductive health is a major health concern all over the world and in developing countries in particular. Lack of nourishment and health facilities resulting from poverty leads to low standards of reproductive health which severely affects not only the women but also the children they produce and this the society accumulates unhealthy malnourished population. Therefore, the status of reproductive health among women and the infrastructure to take care of reproductive health are major indicators of general health infrastructure available to the citizens and development of human index in country.

Concept of Health

Health is a common theme in most cultures. In fact, all communities have their concepts of health, as part of their culture. Among definitions still used, probably the oldest is that health is the “absence of disease”. At individual level, it cannot be said that health occupies an important place; it is usually subjected to other needs defined as more important, e.g., wealth, power, prestige, knowledge, security. Health is often taken for granted, and its value is not fully understood until it is lost. However, it is essential to the satisfaction of basic human needs and to an improved quality of life.

Health is one of those terms which most people find it difficult to define although they are confident of its meaning. Therefore, many definitions of health have been offered from time to time, including the following:

Webster: “The condition of being sound in body, mind or spirit, especially freedom from physical disease of pain”.

Oxford English Dictionary: “Soundness of body or mind; that condition in which its functions are duly and efficiently discharged”. “A condition or quality of the human organism expressing the adequate functioning of the organism is given conditions, genetic and environmental”.

Perkins: “A state of relative equilibrium of body forms and functions which results from its successful dynamic adjustment to forces tending to disturb it. It is not passive interplay between body substance and forces impinging upon it but an active response of body forces working toward readjustment”.

WHO definition: The widely accepted definition of health is that given by the World Health Organization (1948) in the preamble to its constitution which is as follows – “Health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity”. In recent years, this statement has been amplified to include the ability to lead a “socially and economically productive life”.

Health Problems of Indian Women

The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. There is a strong son preference in India, as sons are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters.

Indian women, further, have low levels of both education and formal labour force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons. All of these factors exert a negative impact on the health status of Indian women. Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman's health affects the household economic well-being, as a woman in poor health will be less productive in the labour force.

Many of the health problems of Indian women are related to or exacerbated by high levels of fertility. Uttar Pradesh, the most populous state in India, has a total fertility rate of over 5 children per woman. On the other hand, Kerala, which has relatively high levels of female education and autonomy, has a total fertility rate under 2. High levels of infant mortality combined with the strong son preference motivate women to bear high numbers of children in an attempt to have a son or two survive to adulthood. Numerous pregnancies and closely spaced births erode a mother's nutritional status, which can negatively

affect the pregnancy outcome (e.g., premature births, low birth-weight babies) and also increase the health risk for mothers.

Unwanted pregnancies terminated by unsafe abortion also have negative consequences for women's health. Reducing fertility is an important element in improving the overall health of Indian women. Increasing the use of contraceptives is one way to reduce fertility. While the knowledge of family planning is nearly universal in India, only 36 percent of married women aged 13 to 49 currently use modern contraception. More than half of married women with a high school education or above use contraceptives, compared to only one-third of illiterate women.

Differentials among the religious groups also are pronounced, e.g., Muslims have the highest total fertility rate and the lowest contraceptive use. Despite a large increase in the number of women using contraceptives and limiting their fertility, there is still unmet need for contraceptives in India. Nearly 20 percent of married women in India either want to delay their next birth or have no more children.

Women in rural areas were much less likely to receive prenatal care than women in urban areas. Most women who did not receive health care during pregnancy said they did not because they thought it was unnecessary. Thus, there is a definite need to educate women about the importance of health care for ensuring healthy pregnancies and safe childbirths. Another reason for the low levels of prenatal care is lack of adequate health care centres.

The HIV/AIDS epidemic in India is spreading rapidly and increasingly will affect women's health in coming years. A recent study estimated that between 2 and 5 million Indians are currently infected with HIV. The highest rates of infection are found in population groups with certain high risk behaviours (i.e., sex workers, intravenous drug users, and sexually transmitted disease patients). However, infection also is increasing in the general population. The epidemic is fuelled by both married and unmarried men visiting sex workers who have high rates of infection. Despite the alarming growth of the epidemic, most women in India have very little knowledge of AIDS. Even among those who had heard of the disease, there were many misconceptions about modes of transmission. Indian women could benefit from a strengthened national HIV/AIDS education programme and intervention programmes targeting groups most susceptible to HIV infection.

Objectives of Health Education

Health education is an essential component of any programme to improve the health of a community, and it has a major role in promoting

- (a) good health practices – for example sanitation, clean drinking water, good hygiene, breast feeding, infant feeding and oral rehydration.
- (b) the use of preventive services – for example immunization, antenatal and child health clinics.
- (c) the correct use of medications and the pursuit of rehabilitation regimes – for example, in tuberculosis and leprosy respectively.
- (d) the recognition of early symptoms of disease and promoting early referral.

(e) community support, for primary health care and government control measures.

The main aim of health education is to help women to achieve health by their own actions and efforts. Health education, therefore, begins with the interest of women in improving their conditions of living, and aims at developing a sense of responsibility for their own health betterment as individuals and as members of family and community.

The general objectives of health education are –

(i) To make health a valued community asset:

The valued place in health by women depends mainly on social and cultural factors such as the needs, problems, social organizations, the standard of general education and economic resources of the women.

To enhance the importance of health in one's culture, education encourages women to come together to find ways of tackling problems of their community. The immediate problem concerning the community may not directly be related to health. This active participation and being responsible for their own health is enhanced by insisting the women to find solution to the problems of immediate interest.

(ii) To help individuals to become competent in and carry on those health activities for themselves as individuals or in small groups, in order to realize fully the state of health:

Health is not a commodity which can be bought by individuals for their improvement. Individuals have to accept the scientific knowledge and health practices and act accordingly. Therefore, health education aims at encourage the individual family and community to take responsibility for their own health.

(iii) To promote the development and proper use of health services:

The usefulness of any health service depends on the services provided by the health agency. It depends upon the confidence of people's utilization of the services provided by the health agency. It depends upon the confidence of people in the health personnel and the attitudes which health workers have towards the women. By educating women one can avoid the economic loss incurred by wrong or inadequate use of service.

(iv) Participation of Community Representatives:

Involvement of all members of community in health and family planning programme may not be always feasible and effective for several reasons, of course, in a small community with limited population complete involvement of all the people can be considered. In addition, through small group meetings and campaigns support from entire community can be derived. While involving the community for support, care should be taken and group dynamics be studied properly as involving the local group leader may help in deciding who can be useful and effective in promotion of Health Programmes. For effective community participation we must involve the following people like teachers, community leaders, Sarpanch, Dais,

NGOs, Mahila Mandals. All these can help in increasing the utilization of existing facilities, leading to cost effectiveness of the programme and to reach the goal for health for all.

Different strategies can be adapted for integrating health and nutrition education in Home Science. Through formal as well as non formal education the awareness of health and nutrition education can be imparted. These components are incorporated in teaching, research as well as in extension activities to the non-formal learners. The health education can be effectively integrated in formal classroom teaching as well. Home Science teachings contain considerable health education. The specialization of extension, child development, food and nutrition and home management teach health considerations for either students or the target groups of children, adolescents, and women.

Achieving Gender Equality through Women's Health

Goal 3 of the Millennium Development Goals (MDGs) - to achieve gender equality and empower women - seeks to rectify the disadvantages through policies and programmes that build women's capabilities, improve their access to economic and political opportunity, and guarantee their safety. Such efforts must complement direct health interventions to assure long-term sustainable improvements in women's health.

Indeed, the MDG target for goal 3 is gender parity in primary and secondary schools by 2005 and at all levels of education by 2015. Global commitments to girls' education have focused on primary education. This focus must continue, and international commitments to universal primary education must be met, because primary education results in positive health outcomes that include reduced fertility and child mortality rates. However, post-primary education has strong positive effects on health outcomes and contributes to the broader empowerment of women.

Education is most beneficial to women in settings in which they have greater control over their mobility and greater access to services. In many parts of the developing world, however, women are not allowed that freedom or the resources to improve their health, and health services are not widely available; where present, they are usually of poor quality. In such situations, primary education alone is usually not enough for women to overcome these multiple constraints.

Women can gain the tools and knowledge necessary to overcome these and other obstacles in improving their own health with secondary or higher levels of education. For instance, in countries with a strong societal preference for a son, where girls face substantial discrimination and higher mortality risks than boys, post-primary education enables women to reject gender-biased norms or find alternative opportunities, roles, and support structures.

Female secondary education is associated with high age at marriage, low fertility and mortality, good maternal care, and reduced vulnerability to HIV/AIDS. Girls' secondary school enrolment was inversely related to the proportion of girls married before age 18 years. Those with only primary education (7 years or less) are more likely to be married before age 18 years than are girls with higher education. Secondary female education is strongly associated with low fertility and child mortality.

Women's education improves their use of maternal health services, independent of a host of other factors. Secondary schooling always has a positive effect on a woman's use of prenatal and delivery services and postnatal care. The effect is always much larger than the effect of low levels of schooling. Level of education also affects women's attitudes towards genital cutting. Primary education has a substantial positive effect on knowledge of HIV prevention and condom use, but secondary education has an even greater effect. Girls who attend secondary school are far more likely to understand the costs of risky behaviour and even to know effective refusal tactics in difficult sexual situations.

Female secondary education can have a crucial role in reducing violence against women, which has severe health consequences, including unwanted pregnancies, sexually transmitted infections (including HIV/AIDS), and complications of pregnancy. In some women, the experience of violence can be a strong predictor of HIV. Although female education clearly cannot eliminate violence, secondary education has a stronger effect than primary education in reducing rates of violence and enhancing women's ability to leave an abusive relationship.

In addition to ensuring that girls attain post-primary education, other interventions necessary for gender equality and women's empowerment can also improve health. Improving infrastructure - especially transportation and water and sanitation services - can have substantial benefits for women's health. Accessible and affordable modes of transportation can increase use of health services by women and children. Location of water and sanitation services in or nearby women's homes could reduce head, neck, and back injuries caused by carrying heavy water containers. Better planned sanitation projects also can reduce women's vulnerability to violence. For example, in India, the National Slum Dwellers Federation and Mahila Milan (a women's organisation) build community toilets managed by local women on a pay-and-use system, which greatly improved safety and cleanliness. In Kerala, 49% of women with no property reported physical violence compared with 7% of those who owned property, controlling for a wide range of other factors such as household economic status, education, employment, and other variables.

Gender Development and Women's Mental Health Status

Good mental health is intrinsically important, conferring a subjective sense of emotional well being on the individual woman and extrinsically important, representing a significant resource to the broader society in which she lives and works. A necessary first step towards a socially contextualized health promotion model of women's mental health is to have a definition of mental health which can be usefully applied to women.

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. This definition has several advantages in relation to women's mental health because it:

- i) stresses the complex web of interrelationships that determine mental health and that the factors that determine health operate on multiple levels.
- ii) goes beyond the biological and the individual.
- iii) acknowledges the crucial role of the social context.
- iv) highlights the importance of justice and equality in determining mental well being.

Gender configures both the material and symbolic position women occupy in the social hierarchy as well as the experiences which condition their lives. Understood as a social construct, gender must be included as a determinant of health because of its explanatory power in relation to differences in health outcomes between men and women. These asymmetries are manifested not only in terms of differential susceptibility and exposure to risks - for example vulnerability to sexual violence, but also, fundamentally, in the power of men and women to manage their own lives, to cope with such risks, protect their lives and influence the direction of the health development process. This balance of power has generally favoured men and relegated women to a subordinate, disadvantaged position.

A gendered, social determinants model offers the only viable framework for examining evidence on all relevant factors related to women's mental health. From this perspective, public policy including economic policy, socio-cultural and environmental factors, community and social support, stressors and life events, personal behaviour and skills, and availability and access to health services, may all be seen to exercise a role in determining women's mental health status.

The importance of gender differences in mental health is most graphically illustrated in the significantly different rates of major depression experienced by women compared with men. The need to focus on ill health and morbidity has also been emphasized in the area of women's health. Health related data that is solely bio medically based cannot adequately inform of the morbidity experienced by women. As mortality rates decline, it becomes increasingly critical to address physical and psychological morbidity, increase satisfaction with health care services and improve quality of life, if improvements in women's health are to be achieved.

The tools currently in use to measure health status exacerbate this difficulty by themselves having a gender bias. Reducing morbidity is an essential prerequisite to the improvement of women's mental health. As women in many countries are approximately twice as likely as men to experience depression and it is the most prevalent psychiatric disorder any significant reduction in the overrepresentation of women who are depressed would make an important contribution to lessening the global burden of disease. Women's mental health is a significant public health issue.

The promotion of women's mental health, like health promotion in general, relies on establishing a process composed of a variety of possible elements that singly or together enable women as individuals or members of their communities to increase control over the determinants of their mental health and thereby be in a position to improve their health status and health outcomes. A strong inverse relationship exists between social position and physical and mental health outcomes. Adverse health outcomes are two to two

and a half times higher amongst people in the most disadvantaged social position compared with those in the highest.

Socioeconomic circumstances, social support and health related behaviours all have independent effects on health, but cluster together and are mutually reinforcing. Compared with people in high socioeconomic groups, those in low socioeconomic groups are far more likely to have lower levels of resources, education, poorer living and working environments and lower levels of social support. Health inequalities also derive from other sources including differences related to age, marital status, genetic factors, ethnic background and access to health care and health related information.

As well as differences in access, the quality of the health care women receives when they do encounter the health care system affects satisfaction with care and exerts an influence on psychological health. Being allowed to retain a sense of control and having an active role in decision making has been found to be associated with choosing a medical rather than a surgical termination of pregnancy and in reduced risk of depression following caesarean delivery.

Indigenous people worldwide are particularly likely to experience disadvantaged socioeconomic circumstances, discrimination and poor health outcomes. In reality, reciprocal relationships often exist between health, socio-economic and occupational status, residential location, exposure to health and safety risks, the presence of lifestyle and behavioural risk factors such as unsafe sex, violence, smoking, alcohol consumption, lack of exercise and poor diet, past and present life stressors, community and social support and the availability of health services.

It is vital, therefore, that women's health in general and women's mental health in particular, are examined within a social model which gives an account of the physical and mental health effects of common life stressors and events that are disproportionately experienced by women. Clearly this cannot be confined to childbearing and reproductive events but must also include the impact of poverty, single parenthood, the 'double' shift of paid (often low paid) and unpaid work, employment status, lower wages, discrimination, physical, emotional and sexual violence and the psychological costs of childcare and other forms of caring work.

Where women lack autonomy, decision making power and access to independent income, many other aspects of their lives and health will necessarily be outside their control including their susceptibility to communicable diseases. The different levels of susceptibility and exposure to various kinds of health risks that women face compared with men will inevitably set limits on their opportunities for exercising control over the determinants of their mental health. Elucidating the defining characteristics of women's lives is a necessary precondition for any convincing, socially contextualized account of the gender specific risk factors for adverse mental health outcomes.

Moreover some developing countries outperform richer, industrialized ones in achieving gender empowerment in political, economic and professional activities. Socioeconomic differentials exist in all countries and above a certain level of income, life expectancy and various other health outcomes appear to be most closely tied to inequalities in income or low relative income. For women in general and especially

for those who are members of ethnic minorities and indigenous groups, a critical issue is how income, opportunities and resources are distributed within countries.

Economic growth alone does not guarantee improvements in health, poverty or social justice. Some countries have reduced income poverty when Gross Domestic Product has increased but have still presided over increases in human poverty; other countries have decreased both income and human poverty and yet others have lower levels of human than income poverty. Clearly, economic growth is not a sufficient condition for improvements to human or gender development.

The significance of social capital as a public good that is protective of health but is also vulnerable to erosion and underproduction when left to economic market forces has now been evaluated. Income inequality was strongly correlated with low per capita group membership and lack of social trust. Both were associated with total mortality and specific mortality caused by coronary heart disease, malignant neoplasm and infant mortality. Income inequality appears to be especially influential in poor health.

Women have lower income relative to men and are overrepresented amongst those living in absolute poverty, accounting for around 70% of the world's poor. Inequality and poverty are highly gendered. Any increase in inequality through cuts in the social wage or social welfare or other forms of disinvestment in social capital necessarily fall most heavily on women. The erosion of social capital can proceed as a direct result of changes in economic policy within a country or from conditions attached to financial aid to a country by external donors or such institutions as the IMF or World Bank.

Economic reforms can adversely affect women in a number of ways when governments pursue policies of economic deregulation. If public ownership of basic services like water is transferred into private hands costs can rise, if public housing is sold off and women cannot afford to pay for housing in the private market, homelessness can increase; if social security is cut and welfare entitlements to maternity benefits, childcare and pre-school education are reduced then access is effectively denied and when there is a move to 'casualise' the workforce, women are most affected because 'casualisation' tends to occur most in the areas of employment with the highest rates of female participation, such as the service sector. One of the adverse effects of globalization for women has been an increase in poor quality, insecure jobs and weakened social support systems.

For women in paid work, significantly more receive low wages than their male counterparts. Moreover, relative income inequality penalizing women and favouring men is structurally embedded as women typically earn around two thirds of the average male wage and this disparity has persisted over time. Obviously both men and women are affected by economic adjustment. But what needs to be recognized by policy makers is that this can occur in distinctly different ways for men and women because of the separate roles they play and the different constraints they face in responding to policy changes and shifts in relative prices. The gender specific impacts of changes in economic policy need to be accounted for in any evaluation of their efficacy and the gender neutral assumptions on which such policies proceed must be questioned.

Women have not been consulted about their involvement in various activities or their opinion of health policies whose success depends on that very involvement. By virtue of their higher pre-existing levels of poverty, women are likely to be disproportionately affected by the policies of structural adjustment. Associated health sector reform reinforces this effect. Health sector reform tends to be characterised by reduced government spending on the health care system, 'innovations' such as shorter hospital stays and 'hospital in the home' and the implicit or explicit demand that more will be achieved with less so as to increase efficiency and better 'target' health treatments and interventions. Efficiency can entail job shedding and increase rates of unemployment or less secure employment for nurses and other health care professionals.

Health sector reform can severely impact on women in their assumed gender role as unpaid carers of the sick. Women are expected to cope with an increased burden of more complex care when looking after sick family members who previously would have been able to remain in hospital. As unpaid, 'conscripted' health care workers, it appears that women are meant to simply absorb the personal, financial, emotional and opportunity costs of increased care. Assuming that women not only can but will want to increase their time and commitment to ensure the goals are met of health policy makers on maternal and child health programmes, for example, is another example of this systematic 'oversight' in health policy formulation.

The great advantage of identifying modifiable, social determinants of women's mental health is their alteration and reduction offers the possibility of reducing the incidence of mental health problems. In other words, their identification and reduction can contribute to the primary prevention of such problems. By contrast, even if a great improvement occurred in the detection and treatment of psychological problems once they had developed and were identified in women presenting in general health care settings such a response would only improve secondary prevention. The incidence of such problems and their social determinants would remain unchanged and could continue to rise.

Although justice and equality are essential elements in the attainment of mental health the presence of injustice and inequality, such long standing features of women's lives, has been systematically ignored in research on women's mental health. Perhaps ubiquity confers invisibility. Gender blindness to the possible influence of systemic injustice and discrimination as inducements to depression and despair is readily apparent in the large body of research on how women's reproductive functioning affects their mental health.

It seems astonishing that issues such as forced sterilisation, having one's concerns dismissed or trivialised, not being asked for consent to invasive procedures or tests, being denied privacy or dignity when intimate gynaecological examinations are performed, having low or no access to accurate health information or to safe, effective and affordable methods of fertility regulation, safe care in pregnancy and childbirth and affordable methods of preventing or effectively treating sexually transmitted diseases, have never been seen to play a role in women's emotional well being.

Inadequate reproductive health care and the violation of reproductive rights result in physical harm even death. Despite this, their psychological dimensions have been ignored, almost as if women's bodies and what is done to them had no effect on their minds and could be denied. Just as biological or endocrinological factors alone do not adequately explain women's mental health status or gender disparities in affective disorders; neither do they explain the disproportionate burden of reproductive health problems women face worldwide. These problems are intimately connected to the social; educational (including health educational) economic and political disadvantages women experience and have significant psychological consequences of their own.

Little education, early age at marriage, adolescent pregnancy, repeated pregnancies at short intervals due to lack of access to or the cultural unacceptability of family planning, son preference and less food being given to girls and women, all increase the likelihood of reproductive health problems. All are influenced if not caused by social and cultural, not biological forces. The emphasis on women's reproductive biology is likely to stem from the view that women's health is synonymous with and reducible to those illnesses or conditions related to women's reproductive health.

The splitting of body from mind and the identification of women and their health with the body in general and reproductive functioning in particular has led to a neglect of women's mental health and its social structural determinants. Using biological difference from men as the chief organising principle, women's health, in the past, was seen to fit within the ambit of obstetrics and gynaecology.

The role of the woman in healthy nutrition

The role of the woman in healthy nutrition includes feeding the newborn, preparing meals for members of her family, and her extensive professional involvement in food manufacturing, trade, public catering, health care and education. Women have traditionally been responsible for buying food and preparing meals, so their competence in matters of healthy nutrition will largely determine the health of families and, accordingly, of society. Given this, one could safely state that it is the woman who has the key role in society in implementing a healthy nutrition policy, both in her own family and in society as a whole.

Women's health status as well as their social status have a great impact on the health of their children and therefore of the future generation. There is a correlation between women's level of education and babies' birth weight: the higher the level of education, the greater the birth weight. It is well known that low birth-weight babies suffer from anaemia and experience retardation of their growth and development. Eventually, this determines the intellectual and physical potential of society. If the mother herself has a low body mass, this will result in the birth of a baby with a low body mass, which is significant or the long-term health of society. Information regarding healthy nutrition during pregnancy and breastfeeding newborn babies and infants in the first year of life will allow not only the health of the woman, but also that of the child, to be protected against infectious diseases during the first year of life and no communicable disease in adult life.

The role of the woman in implementing a healthy nutrition policy in the family is important as, being aware of the basic principles of healthy eating and implementing them, the woman can ensure the implementation of a healthy nutrition policy in her family. Given the role of women in sectors relating to the manufacture and distribution of foods, she is also capable of implementing a healthy nutrition policy in the society.

Social action to promote the role of women in a healthy nutrition strategy

The social role of women can be discussed in three main social functions of women, such as:

1. **women as a target group for information:** women as part of the general public can be targeted with social marketing campaigns;
2. **women as agents for change:** given the role of women in families and their influence on family members (on the foetus during pregnancy, on the children and men), women can be a medium through which influence is exerted on different subgroups of the population;
3. **women as initiators of change:** in terms of both their numbers and influence on society, women hold leading positions in a number of spheres, e.g. in public health, education, trade and children's preschool institutions.

The potential women have to implement a healthy nutrition programme remains virtually unused. This is due mainly to lack of knowledge, availability of and access to healthy foods and economic difficulties faced by families.

In view of the important role of women, strategies required to achieve this multi-faceted role could be summarized under the following headings.

Public education strategy

If they are given the correct information, women can educate their children, husbands and relatives. The following channels could be used to implement this strategy:

- the mass media - especially women's magazines and TV programmes on cooking
- dietary guidelines and recommendations by doctors and teachers
- the retail trade
- public catering
- NGOs (especially women's organizations)

A strategy for professional healthy nutrition training

Women act as professionals in the health, education, trade and public catering sectors. In their professional capacities they could be involved in the following:

- providing training at the graduate and postgraduate levels
- developing guidelines and manuals
- providing recommendations for patients and students
- changing the public catering sector
- influencing policy-makers by advocating policy change

A strategy for involving the general public

The general public can be involved through:

- NGOs
- professional associations

On the basis of these strategies, some practical steps are as follows:

- educating women about healthy lifestyles through the mass media (especially women's magazines), including the basic principles of providing healthy nutrition for their families;
- educating those in institutions for preschool and schoolchildren about healthy nutrition, taking due regard of the age of the children;
- teaching college and university students about special healthy lifestyle programmes, which include healthy nutrition issues;
- modifying the training programmes of food industry specialists, including public catering, trade and others whose work is related to the nutrition of the population;
- developing special programmes for educating women and their families as to how to amend inappropriate dietary habits;
- teaching practical skills and the basic principles of healthy nutrition within the systems of general education and vocational training, home economics lessons and housekeeping, but also within the food industry, public catering and retail trade;
- training women specialists who are employed within the food industry, retail trade, public catering and health and education sectors, etc. under special programmes at enterprises that manufacture and market healthy foods;
- developing and approving, in accordance with established procedures, rules for manufacturing healthy foods, including the production of ready-made dishes;
- implementing a system of official recognition at food industry enterprises, public catering and retail trade, whereby healthy foods certificates would be issued; and
- writing and publishing special literature on healthy nutrition within the family, reflecting such issues as growing foods, processes for producing healthy foods, breastfeeding and the economic aspects of healthy nutrition.

Conclusion

Now, we have to value our health as our “valuable asset”. It is in our hand to maintain our health as only a healthy person can lead a healthy and productive life. Health is our nature and illness is an attack on nature. Health, like life, is a process – a constant flux. It is not a state that can be permanently attained. Health and nutrition education aims at enabling women and men both to gain control over the determinants of health and health behaviour and the condition that affect their health status. The decisions and actions by various sectors of society do influence the health and living conditions of not only people belonging to that sector but that of the society and the generation as a whole. Health education has therefore to play a key

role in influencing all health related sectors to see that their policies and actions are in congruence with the national health objectives. It has to play a key role of an advocacy so that people are motivated and play effective role in educating and adapting sound health practices. Thus, it is well said that “Health is beauty”, as beauty is only a by-product of good health. So, let’s wake up and enter into the adventure and remember that Health is a fundamental Human Right.

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