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Women Health in India: An Analysis

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Abstract

If health is defined 'as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', it follows that existence is a necessary condition for aspiring for health. The girl child in India is increasingly under threat. In recent decades, there has been an alarming decrease in the child sex ratio (0-4 years) in the country. Access to technological advances of ultra sonography and India's relatively liberal laws on abortion have been misused to eliminate female foetuses. From 958 girls to every 1000 boys in 1991, the ratio has declined to 934 girls to 1000 boys in 2001. In some states in western and north western India, there are less than 900 girls to 1000 boys. The sex ratio is at its worst in the states of Punjab, Haryana, Himachal Pradesh and Gujarat, where severe practices of seclusion and deprivation prevail. Often in contiguous areas in these states, the ratio dips distressingly below 800 girls to every 1000 boys (RGI, MOHFW, UNFPA, 2003). Annexure I gives the child sex ratio in different states and union territories of India as per the 2001 census. The Present paper analysis the Nutrition and women health in India.

Keywords: Women, Health, Nutrition.

Introduction

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. Further, Indian women have low levels of both education and formal labor force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons[1]. 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 labor force. While women in India face many serious health concerns, this profile focuses on only five key issues: reproductive health, violence against women, nutritional status, unequal treatment of girls and boys, and HIV/AIDS. Because of the wide variation in cultures, religions, and levels of development among India's 25 states and 7 union territories, it is not surprising that women's health also varies greatly from state to state. To give a more detailed picture, data for the major states will be presented whenever possible.

The discrimination against the girl child is systematic and pervasive enough to manifest in many demographic measures for the country. For the country as a whole as well as its rural areas, the infant mortality rate is higher for females in comparison to that for males. Usually, though not exclusively, it is in the northern and western states that the female infant mortality rates are higher, a difference of ten points between the two sex specific rates not being uncommon. The infant mortality rate is slightly in favour of females in the urban areas of the country (as a whole) But then, urban India is marked by greater access to abortion services and unwanted girl children often get eliminated before birth. It has been commented in the context of women's health that sustainable well-being can be brought about if strategic interventions are made at critical stages. The life cycle approach thus advocates strategic interventions in periods of early childhood, adolescence and pregnancy, with programmes ranging from nutrition supplements to life skills education. Such interventions attempt to break the vicious intergenerational cycle of ill health. The vulnerability of females in India in the crucial periods of childhood, adolescence and childbearing is underscored by the country's sex wise age specific mortality rates. From childhood till the mid twenties, higher proportions of women than men die in the country. In rural India, higher proportions of women die under thirty.

Like most cultures across the world, Indian society has deeply entrenched patriarchal norms and values. Patriarchy manifests itself in both the public and private spheres of women's lives in the country, determining their 'life chances' and resulting in their qualitatively inferior status in the various socio-economic spheres. It permeates institutions and organisations and works in

many insidious ways to undermine women's right to dignified lives. There are similarities in women's lived experiences due to such gendered existences. However, in a vast and socio-culturally heterogeneous country like India, women's multiple and often special needs are played out on a variegated terrain of age, caste, class and region resulting in a complexity of experiences. Traditional bases of social stratification such as caste and class reproduce themselves in women's lived experiences as also do rural-urban and regional disparities. New needs emerge as women progress through the life cycle. Talking about women's health and access to healthcare in such a complex setup thus poses a challenge.

Women Health in India

Health is complex and dependent on a host of factors. The dynamic interplay of social and environmental factors have profound and multifaceted implications on health. Women's lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. But gender identities are played out from various location positions like caste and class. The multiple burdens of 'production and reproduction' borne from a position of disadvantage has telling consequences on women's well-being. The present section on women's health in India systematizes existing evidence on the topic. Different aspects of women's health are *thematically* presented as a matter of presentation and the themes are not to be construed as mutually exclusive and water tight compartments. The conditions of women's lives shape their health in more ways than one.

The population of the world crossed 6 billion in 1999, and India's population crossed 1 billion in 2000. In 2011, India's population is expected to be around 1.2 billion. Some indicators on the quality of life in Asian countries, including India have improved over the years such as life expectancy, literacy and infant mortality, while others have remained static or deteriorated such as environmental sanitation and environmental degradation. International comparisons on a few of the indicators of human development for Asian countries and indicators for different states in India are given in the tables below.

Nutrition

Nutrition is a determinant of health. A well balanced diet increases the body's resistance to infection, thus warding off a host of infections as well as helping the body fight existing infection. Depending on he nutrient in question, nutritional efficiency can manifest in an array of is orders like protein energy malnutrition, night blindness, and iodine deficiency is orders, anaemia, stunting, low Body ass Index and low birth weight. Improper nutritional intake is also responsible for is eases like coronary heart disease, ypertension, non-insulin-dependent diabetes mellitus and cancer, among there[2]. Nutritional deficiency disorders of different types are widely prevalent in the countries of south East Asia, with some pockets showing infelicity in certain types of disorders. iodine deficiency disorder is endemic to he Himalayan and several tribal areas and anaemia is a pervasive problem across most socio-economic groups of the country.

Table-1
Indicators of Human Development for SAARC Countries and Some Asian Countries, 2008

Country	Life Expectancy at Birth (years)	Infant Mortality Rate (Per thousand live Births)	Adult Literacy Rate (%) (age 15 years & above)
India	64	54	66
Bangaladesh	64	47	54
Bhutan	66	56	56
China	73	19	93
Indonesia	70	25	91
Malaysia	74	10	92
Maldives	68	26	97
Nepal	64	43	57
Pakistan	65	73	55
Philippines	72	23	93
Srilanka	72	17	92
Thailand	70	6	94

Notes: Literacy Rate for Kerala is for 7 years and above, b: Data refer to estimates for the period 2000-2007. **Source:** United Nations Children's Fund. (2009). The State of the World's Children 2009: Maternal and Newborn Health. New York: UNICEF. p. 118-121. *India, Registrar General, Vital Statistics Division. (2009). Sample Registration System Bulletin April 2009.New Delhi. p. 5. $ India, Registrar General and Census Commissioner. (2001). Provisional Population Totals: Paper 1 of 2001: Census of India 2001. New Delhi. p. 143.

Economic prosperity alone cannot be a sufficient condition for good nutritional status of a population, the state of Maharashtra in western India being a prime example in this regard. Maharashtra has one of the highest per capita incomes among states in the country, but is marked by poor nutritional profile of its people. More than half the households in both the rural and urban areas of the state receive less than the prescribed adequate amount of calorific intake and the situation has worsened in the rural areas of the state in the past twenty years[3]. The nutritional status of children and women in India has attracted the attention of academics and policy planners for some decades now. Despite the interest, these population subgroups continue to suffer from poor nutritional status. The girl child, disadvantaged from birth (or even before it) due to her sex, is systematically denied or has limited access to the often paltry food resources within the household. A recent study of three backward districts of Maharashtra shows that in the project areas of the ICDS (the Integrated Child Development Services-the state run programme designed to ameliorate the nutritional status of children and pregnant and nursing women with the help of supplementary nutrition), the girl beneficiaries consistently showed poorer weight for age results, compared to the boy beneficiaries[4].

This was true for all the three project defined age groups of children below one year; between one and three years and between three and six years. All the three districts of Jalna, Yawatmal and Nandurbar displayed such a consistency. The three districts encompass considerable sociocultural heterogeneity, Jalna being a predominantly non-tribal district while Yawatmal has a mixed tribal-nontribal population. The district of Nandurbar has a predominantly tribal population. National level estimates from the NFHS-2 also show that girls are more likely to be undernourished or even severely undernourished for the indicators of weight for age and height table 2. More girls than boys are thus underweight and stunted. Boys are slightly more likely to show undernourishment and severe undernourishment in the case of weight for height, that is, they are more likely to be thin than the girls. Women's physiological makeup calls for special nutritional supplements. Menstruation and childbirth are iron depleting physiological processes. Calcium needs to be continually supplemented during a woman's life cycle as a bulwark against osteoporosis in later life. The predominantly vegetarian diet of Indians does not fulfill many of their nutritional requirements. Further, cultural practices disadvantage women in many ways and add to their poor nutritional status. It is customary in many households across the country that the women should eat last and eat the leftovers after the men folk have had their food[5].

Formal healthcare

The formal healthcare setup in India is huge and diverse. Sectoral plurality and functional diversities mark the provisioning of healthcare in the country. The privileging of the biomedical model in medical colleges across the country reflects in various ways, ranging from textbooks that are often gender blind/ insensitive to providers' attitudes that may display lack of understanding of socioeconomic causes underlying ill health. The public sector has a considerable and diverse physical presence, largely owing to the gains made prior to the 1990s. The public healthcare infrastructure ranges from a sub-centre in a village to multi-specialty, multi-bedded hospitals in urban areas. Primary Health Centers, Rural Hospitals, Civil Hospitals as well as a host of facilities like municipal hospitals and clinics are some of the other public healthcare facilities. The state may also run health facilities dedicated to specific diseases (for example, leprosy clinics) or specific population sub groups (for instance, Central Government Health Scheme). The structure of the public health sector is thus fairly well defined. In the 1990s, there has been uneven growth in the number of Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub-centers (SCs) in the different states and union territories of India.

While some states have witnessed considerable increase in such facilities, the progress has been very slow or stagnant in others. For the country as a whole, tribal areas are deficient in the three types of public facilities set up for providing primary healthcare, the deficiency being severe for Community Health Centres. Barring a few states and union territories, the others have deficiencies in the three types of public facilities.

Table-2
Nutritional Status by Sex of the Child

	Weight for age		Height for age		Weight for hight	
Sex of the Child	**% below -3 SD**	**% below -2 SD**	**% below -3 SD**	**% below -2 SD**	**% below -3 SD**	**% below -2 SD**
Male	16.9	45.3	21.8	44.1	2.9	15.7
Female	19.1	48.9	24.4	47.0	2.7	15.2

Source: NFSH2, *Note:* The indices are expressed in standard deviation units (SD) from the median of the International Reference Population. • Includes children who are -3 SD below the median of the International Reference Population.

Table-3
Progress of Indian Women, 2008

Development Indicators	Women	Men	Total	Women	Men	Total
1. Demography						
- Population (in million in 1971 & 2001)	264.1	284.0	548.1	495.7	531.2	1027.1
- Decennial Growth (1971 & 2001)	24.9	24.4	24.6	21.7	20.9	21.34
2. Vital Statistics						
- Sex Ration (1971 & 2001)	930	-	-	933	-	-
- Expectation of Life at Birth (1971 & 2001-06)	50.2	50.5	-	66.91	63.87	-
- Mean Age at Marriage (1971 & 1991)	17.2	22.4	-	19.3	23.9	-
3. Health and Family Welfare						
-Birth Rate (1971 & 2008)	-	-	36.9	-	-	22.8
-Death Rate (1970 & 2008)	15.6	15.8	15.7	6.8	8.0	7.4
-Infant Mortality Rate (1978 & 2008) Per 1000 live Births	131	123	127	55	52	53
-Child Death Rate (2007) (0-4 years) (2007) (5-14 years)	-	-	-	16.9 1.2	15.2 1.1	16.0 1.2
-Maternal Mortality Rate (1980 & 2008)	468	-	-	254	-	-
4. Literacy and Education						
- Literacy Rates (1971 & 2001)	7.9	24.9	16.7	54.28	75.96	65.38
-Gross Enrolment Ratio (1990-91 & 2006-07) (%)						
Class I-V	85.5	113.9	100.1	107.8	114.4	111.2
Class VI-VIII	47.8	76.6	62.1	69.5	77.4	73.6
-Drop Out Rate (1990-91 & 2006-07) (%)						
Class I-V	46	40.1	42.6	26.6	24.4	25.4
Class VI-VIII	-	-	-	45.3	46.6	46.0
5. Work and Employment						
- Work Participation Rate (1971 & 2001) (%)	14.2	52.8	34.3	25.68	51.93	39.26
- Organised Sector (No. in lakhs in 1971 & 2006)	19.3 (11%)	155.6	174.9	51.21 (19%)	218.72	269.93
-Public Sectro (No. in lakhs in 1971 & 2006)	8.6 (8%)	98.7	107.3	30.03 (16.51%)	151.85	181.88

Notes: @ Refers to 1995 in respect of only 9 States viz. Gujarat, Haryana, Kerala, Madhya Pradesh, Punjab, Rajasthan, Tripura and West Bengal. Figure in parentheses indicate the percentage in the total and year of the data in respective columns. Data from Planning Commission. **Source:** India, Ministry of Human Resource Development, Department of Women and Child Development. (2001). Working Group on Empowerment of Women: Tenth Plan (2002-07): Report. New Delhi. p.43. India, Ministry of Human Resource Development, Department of School Education and Literacy. (2009). Annual Report 2008-09. New Delhi. p. 307-08, 317-18. India, Registrar General. (2008). Sample Registration System: Statistical Report 2007. New Delhi. p. 83 84. India, Registrar General. (2009). Sample Registration System Bulletin, October 2008. New Delhi. p. 1-5.

The private health sector in the country is large and amorphous, and chiefly engaged in curative care. The not-for-profit sector (including services by non governmental organisations) is also present in many urban and rural areas of the country. There is remarkable diversity in the private sector in terms of the systems of medicine practiced, the type of ownership (ranging from sole proprietorship to partnerships and corporate entities), and the services provided. The private sector has a presence in most medium to big villages as well as in towns and cities. However, facilities with technologically advanced equipment and offering varied specialisations are almost always in the big urban areas. In terms of sheer numbers as well, the private sector is disproportionately concentrated in the urban areas. Large scale national surveys like the NSS and the NFHS, as well as numerous smaller studies report that the private sector is the dominant sector in healthcare. The 52nd round of the NSSO carried out in the mid 1990s estimates that the private sector accounts for nearly 80% of non-hospitalised treatments in both rural and urban areas, up by 7-8 percentage points from the estimates of the 42nd NSSO round in the mid 1980s NSSO, 1998b. For hospitalised treatment, the public sector has lost out to the private sector in the 1990s, in contrast to the 1980s when the public sector accounted for the majority of the hospitalised treatments in both rural and urban areas of the country (ibid). Client satisfaction is higher in the private sector along indices like behaviour of the staff, privacy accorded, amount of time spent, etc. Despite its ubiquity and appeal, the private healthcare sector in India is poorly regulated and operates with little accountability with respect to its actions[6]. Allegations of irrational practices and even malpractices are not uncommon

against the private sector in India. A large number of studies (micro as well as large scale macro studies) have pointed out the high cost of treatment in the private health sector of the country, the costs being many a time more than double of that incurred in the public sector.

Conclusion

Women's empowerment is hindered by limited autonomy in many areas that has a strong bearing on development. Their institutionalised incapacity owing to low levels of literacy, limited exposure to mass media and access to money and restricted mobility results in limited areas of competence and control (for instance, cooking). The family is the primary, if not the only locus for them. However, even in the household domain, women's participation is highly gendered. Nationally, about half the women (51.6%) are involved in decision making on their healthcare. Women's widespread ignorance about matters related to their health poses a serious impediment to their well-being. The NFHS-2, for example, reports that out of the total births where no antenatal care was sought during pregnancy, in 60 percent of the cases women felt it was 'not necessary'. And, at a time when AIDS is believed to have assumed pandemic proportions in the country, 60 percent of the ever married women have never heard of the disease. Women's inferior status thus has deleterious effects on their health and limits their access to healthcare.

The household has been seen to be a prominent site for gender based discrimination in matters of healthcare in a number of other studies too. Marriage in India is predominantly patrilocal with the new bride relocating to her marital house after marriage. Early marriage usually follows a truncated education, disadvantaging girls in many ways. In such a setup, the new bride, already ignorant about health processes, may be in a difficult position to seek healthcare. Basua and Kurz report from their study on married adolescent girls in Maharashtra that 'girls had neither decision making power nor influence' in matters relating to seeking healthcare for their problems[7]. These illnesses that incapacitated girls from discharging their household responsibilities were treated quickly. The culture of silence prevented care seeking in problems related to sexual health. Some reproductive health problems went untreated because they were considered 'normal'. In the Nasik study by Madhiwalla, et.al, 45% of the episodes of ill health in women went untreated[8]. In most cases it was financial incapacity that precluded women from seeking treatment. But, quite notably, in almost a quarter of the cases, women thought that the illness did not require medical attention. Treatment was also not sought for reasons like inaccessibility /inadequacy of the health facilities.

Reference

1. Chatterjee Meera, Indian Women: Their Health and Economic Productivity, World Bank Discussion Papers 109, Washington, DC. **(1990)**

2. Shetty P.S., Food and nutrition. In Detels, R., J. McEwen, R. Beaglehole and H. Tanaka (eds.) *Oxford Textbook of Public Health* (fourth edition), New York: Oxford University Press, 149-170 **(2004)**

3. Duggal R., Health and nutrition in Maharashtra. In Government of Maharashtra (2002). *Human Development* Report: Maharashtra, New Delhi: Oxford University Press, 53-77 **(2002)**

4. Mishra M., Duggal R. and Raymus P., Health and healthcare situation in Jalna, Yawatmal and Nandurbar.(Report submitted to the Indira Gandhi Institute for Development Research (IGIDR), Mumbai as part of the Maharashtra Human Development Report Followup Study sponsored by the UNDP, New Delhi, and the State Planning Board, Government of Maharashtra). Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT) **(2004)**

5. Dube L., on the construction of gender: Hindu girls in patrilineal India. In Karuna Channa (ed.) *Socialisation, Education and Women: Explorations in Gender Identity.* New Delhi: Orient Longman 166-192 **(1988)**

6. Nandraj S., Beyond the Law and the Lord: Quality of Private Health Care. Economic and Political Weekly, **29(27),** 1680-1685 **(1994)**

7. Basu A. and Kurz. K., Reproductive health seeking by married adolescent girls in Maharashtra, India, *Reproductive Health Matters*, 9(17), 52-62 **(2001)**

8. Madhiwalla N., Nandraj S. and Sinha R., Health households and women's lives: A study of illness and childbearing among women in Nashik district, Maharashtra. Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT) **(2000)**