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# A STUDY ON THE STATUS OF WOMEN HEALTH IN INDIA

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## ABSTRACT

Given that "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 one must already be alive in order to wish to become healthy. The protection of young Indian women has emerged as a major issue. There has been a dramatic decline in the sex ratio of children less than four years old across the country during the previous few decades. In India, it is increasingly popular to abort female foetuses, taking advantage of modern medical advancements like ultrasonography and the country's relatively liberal abortion laws. In 1991, there were 958 more women than men per 1,000, but by 2001, the gender ratio had reversed to 934 females to 1,000 males. Several states in western and northern India have fewer than 900 girls for every 1000 boys. Punjab, Haryana, Himachal Pradesh, and Gujarat are home to some of India's worst societal practices, including isolation and poverty, and consequently have some of the poorest sex ratios in the country. RGI, MOHFW, and UNFPA (2003) report that the ratio lowers to an alarmingly low level in these states, typically falling below 800 girls per 1000 boys in adjacent areas. displays data from the 2001 census that breaks down the gender makeup of Indian children by state and union territory. This research looks on how dietary habits affect the health of Indian women.

***Key Word:*** *Women, Health.*

## INTRODUCTION

Indian women's health is significantly correlated with their socioeconomic status. Research on the status of women in India reveals that despite their many positive contributions to society, Indian women are often seen as a financial burden by their male counterparts. Males are expected to take care of their old parents, hence there is a strong preference for having sons over daughters in India. Due to society's preference for boys and the high costs of marrying a woman, girls are sometimes subjected to abuse. Furthermore, Indian women's participation in the formal job sector lags much behind their educational achievement. They often have little autonomy since they answer to their fathers, then their husbands, and finally their sons1. All of these issues are currently having a negative impact on the health of Indian women. When a woman's health is bad, not only does she feel the effects, but so do her children and other loved ones. Babies born to unhealthy mothers have a higher chance of being born premature or with a low birth weight. They are also less likely to have enough money to feed and care for their kids, increasing the risk that some of those kids may go hungry. Finally, a woman's health affects the family's financial well-being. This is due to the fact that a woman's productivity in the workplace would suffer if she is unwell. Although women in India face a wide range of serious health challenges, this profile focuses on just five of them: reproductive health, violence against women, nutritional status, unequal treatment of girls and boys, and HIV/AIDS. Since India is made up of 25 states and 7 union territories, each of which has its own unique set of cultural norms, religious traditions, and socioeconomic position, it is not unexpected that there are significant differences in women's health from one region to the next. To give a more complete picture, we will include data for the most populous states where

possible. Inequality in the treatment of female children is so pervasive and systemic in this country that it may be observed in many different types of demographic data. In both urban and rural areas, the mortality rate per 1,000 live births for female newborns is much higher than that for male infants. While the fatality rate for female newborns is often higher in the northern and western states, this is not always the case. In these areas, it is not uncommon to see a death rate gap of 10 percentage points between men and women. There is a little edge for women over men when it comes to the infant mortality rate in the country's major cities. Greater access to abortion clinics in metropolitan India, however, implies that unwanted female newborns can be killed before they are born. Some researchers have proposed that deliberate treatments at important life stages may be able to improve women's health in the long run. Therefore, the life cycle approach encourages deliberate interventions throughout all crucial periods, including infancy, adolescence, and pregnancy. Nutritional supplements and lessons in self-care are only two examples of the forms these therapies might take.

By addressing the underlying causes of a patient's condition, therapies like these aim to break the cycle of bad health that may be handed down through the generations. Differences in mortality rates across sexes and across age groups in India provide light on the vulnerability of Indian women during childhood, adolescence, and motherhood. This increases the likelihood of mortality for women in India. Women have a higher mortality rate than men in this nation between the ages of one and twenty-five. Women under the age of 30 have a far higher risk of dying in rural parts of India. The norms and values of patriarchy are deeply rooted in Indian culture, as they are in the cultures of the globe at large. Patriarchy, which manifests itself in both the public and private sectors of women's existence in the country, determines both their 'life chances' and their qualitatively inferior status in the many socio-economic domains. Women in this country face patriarchy in all spheres of society. It permeates societal establishments and uses subtle tactics to impair women's ability to lead respectable lives. Because of the constraints of their gender, women tend to go through life together. However, in a country as large and culturally diverse as India, women's varying and often distinct needs are played out on a terrain that varies according to age, caste, class, and region, resulting in a rich tapestry of perspectives and experiences. This is especially important when considering the health care needs of women. Traditional bases of social stratification like as caste and class, as well as rural-urban and regional inequalities, continue to exhibit themselves in women's lived experiences. The needs of women change at different stages of their lives. Women's health and access to medical treatment is a complex topic, which makes having a discourse about it challenging.

**NUTRITION**

One's diet might have an effect on their overall health. Eating a nutritionally balanced diet not only aids the body in fighting off illnesses it currently has, but also protects it against developing new infections by increasing the body's resilience to infection. Protein and energy malnutrition, night blindness, iodine deficiency, anemia, stunting, low Body Mass Index, and low birth weight are just few of the many manifestations of nutritional inefficiency. Coronary heart disease, high blood pressure, type 2 diabetes, and cancer are just a handful of the many ailments that have been linked to poor eating habits. Nutritional deficiencies, in its many manifestations, are quite common across the countries of southeast Asia. However, certain areas of the region show an uneven distribution of some diseases. Throughout the bulk of the country's socioeconomic groups, anemia is common, and iodine deficiency sickness is endemic to the Himalayan region and other tribal communities.

Because economic growth alone is insufficient to ensure a population will have a healthy nutritional condition, the state of Maharashtra in western India offers as a paradigmatic example in this respect. Maharashtra has one of the greatest per capita wages while having one of the lowest nutritional profiles of any state in the country. More than half of families in both urban and rural sections of the state consume less calories than is considered healthy, and the problem has worsened considerably in the state's rural areas during the past two decades. The nutritional status of children and women in India has been a topic of study and discussion among academics and policymakers for decades. Despite all the focus, some groups within the population are still severely malnourished. A girl's sex puts her at a disadvantage from the moment she is born (or perhaps before), and this disadvantage is reinforced by the fact that she is often denied or has only limited access to the meager household food supplies. Integrated Child Development Services (ICDS) is a state-run program that aims to improve the nutritional status of children as well as pregnant and nursing women with the assistance of supplementary nutrition, but a recent study conducted in three underdeveloped districts of the state of Maharashtra found that in the project areas of the ICDS, the girl beneficiaries consistently showed poorer weight for age results when compared to the boy beneficiaries. This was in contrast to the outcomes shown in the male recipients. This was true across all three of the targeted age ranges for the project: infants and toddlers, preschoolers, and elementary schoolers. Jalna, Yawatmal, and Nandurbar all showed regional coherence comparable to the entire. Jalna has the lowest percentage of tribal residents among the three districts, whereas Yawatmal has a mixed tribal and non-tribal population. The districts have a wide gap in terms of socioeconomic status.

The Nandurbar district is home to a large number of people who trace their ancestry back to tribal groups. Girls were at a substantially greater risk of being undernourished, or perhaps severely undernourished, based on their weight in proportion to their age and height, according to national estimates generated from the NFHS-2. Therefore, girls are disproportionately affected by underweight and stunted development compared to boys. To put it another way, boys are more likely to be underweight than girls, as measured by their body mass index (BMI), or weight in relation to their height. Women, because of their unique anatomy and physiology, should take nutritional supplements designed specifically for them. Iron reserves are depleted in the body due to the physiological processes of menstruation and childbirth. To reduce her risk of developing osteoporosis in old age, women should take calcium supplements regularly. Indians require supplemental sources of a number of nutrients since their vegetarian diet falls short. Cultural norms that discriminate against women further diminish their chances of getting enough nourishment. In many households across the country, the women eat last and finish whatever is left on their plates after the men have finished their meals.

## OBJECTIVES OF THE STUDY

1. To the study of women health.
2. To the study of nutrition.

## INDIAN WOMEN'S HEALTH SITUATION CURRENTLY

Empowerment requires full freedom. India's women's status has changed dramatically throughout millennia. This study examines India's women's empowerment and its effects on health indicators. Social, political, and economic environments affect women's mental, social, and physical health. These variables affect women's health. Despite India's size and diversity (socially, culturally, and economically), the inequality between men and women, as well as between women of different geographical regions, social classes, and indigenous and ethnic groups, is the biggest barrier to women's healthcare access. Our culture contributes to women's current

status. Women have had worse malnutrition since birth. Many governments that support illicit sex determination and female foeticide favor male children. This threatens the pregnant woman's physical and mental health and disrupts the sex ratio, which causes numerous social issues.1 The family typically sees the girl kid as a financial burden due to cultural norms like dowries. This is a major cause of sex determination and female foeticide in various locations. Women's fertility and medical abortion decisions are often influenced by their husbands or family members. Although female fertility has dropped in certain regions, female foeticide continues and the desire for male offspring remains high. In patriarchal nations like India, women have less power, autonomy, independence, and money than men. They take care of the spouse, children, and elderly, doing household duties and medical treatment when needed. The patrilineal structure of these civilizations, which restricts property and title inheritance to men, drives the desire for sons.4 Despite all, family women keep everything together. Family health issues can emerge throughout conception and pregnancy, infancy, youth, adolescence, adulthood, and old age, as well as in the setting of various familial ties.

A unfavorable pregnancy outcome affects the woman, the child, the family, and the community physically, emotionally, and financially. Indian society suppresses women's rights, causing health issues for mothers and children. Maternal mortality is India's biggest cause of death for women, despite being one of the country's top health care priorities. 212 mothers die per 1000 live deliveries, six times the Chinese average. After a woman gives birth, it seems like everyone puts her health second. Comparing the percentage of women in each state who get postpartum care in the first two days following birth provides a glimpse.8 Table 1 Mothers who don't obtain prenatal care or give birth without help often make child care mistakes. Thus, child health issues increase the infant mortality rate (IMR). Young marriage and childbirth contribute to the MMR and IMR. Nearly one in three young women in emerging nations, save China, are married before 18. Early marriage is known to harm young women's sexual and reproductive health, as well as their children's.9, 10 'Domestic violence' shows women's status in modern society. Married women over 18 are less likely to be abused. They may have a better grasp of marriage, sexuality, and its consequences, as well as more time to mature physically and psychologically. Women are more likely to participate in marriage decisions if they marry later in life. Researchers found a strong relationship between intimate partner violence and infant mortality. Domestic violence damages a woman's body and reproductive health. In addition, husband-perpetrated physical abuse and acceptance of the justification for such violence are significantly linked to a decreased chance of seeking assistance. The gender inequality and mortality research found that Indian men and women have similar life expectancies (65.77 and 67.95 in 2011).

**Table 1: Some of the NFHS-3's indicators pertaining to women's health for certain states**

| | Very young mothers <19 years | Median age of mother at first birth | % Children fullyimmunized | % Women participate in household decisions | % Mothers received proper postnatal care | % Women experienced spousal violence |
|---|---|---|---|---|---|---|
| Kerala | 5.8 | 22.7 | 75.3 | 47.2 | 87.7 | 16.4 |
| Tamilnadu | 7.7 | 21 | 80.9 | 48.8 | 89.6 | 41.9 |
| Bihar | 25 | 18.7 | 32.8 | 32.7 | 15.9 | 59 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Rajasthan | 16 | 19.6 | 26.5 | 22.8 | 29 | 46.3 |
| Delhi | 5 | 21.7 | 63.2 | 52 | 50.4 | 16.3 |
| Gujarat | 12.7 | 20.6 | 45.2 | 36.6 | 54 | 27.6 |
| Indicators for only uneducated women : | | | | | | |
| Kerala | * | 18.9 | * | 47.8 | * | 26 |
| Tamilnadu | * | 19.4 | 78.3 | 49.7 | 78.1 | 52.9 |
| Bihar | 35.3 | 18.3 | 21.9 | 35 | 9.9 | 63.6 |
| Rajasthan | 22.8 | 19.3 | 20.5 | 20.5 | 19.7 | 50.4 |
| Delhi | 24.6 | 19.4 | 44.2 | 50.4 | 24.5 | 28.9 |
| Gujarat | 37.9 | 19.4 | 27.7 | 34 | 36.5 | 34.3 |

This minor discrepancy also reflects the country's poor women's status.Women's education is crucial to growth. Table 1 shows how women's empowerment affects health across states.8 Kerala has 4.8% underage female marriage, compared to 41.2% in West Bengal, 42.7% in Rajasthan, and 45.6% in Bihar.16 Kerala has 1053 sex ratios compared to 898 in Uttar Pradesh, 919 in Bihar, and 934 in WB.17 Bihar has 47% literacy, with 59.7% male and 33.1% female. Kerala has 90.9% overall, 94.2% male, and 87.7% female literacy, while WB has 68.6%, 77%, and 59.6%. Bihar lags behind Kerala in literacy and education.8 Kerala's IMR is 11 per 1000 live births, compared to Bihar's unavailable 2008 statistics, Uttar Pradesh's 81, and Madhya Pradesh's 86.8 Kerala's 99.3% prenatal care rate compared to Bihar's 28.1% shows women's health awareness and health care availability.8 Kerala's superior statistics may be due to free and educated women who can care for their children's education and health. Bihar has poor school enrollment. Bihar's 1st–6th dropout rate is 48 for both sexes. In Bihar, 69% of females marry before 18, and 75% in rural regions.8 Kerala has 1.9 children per woman, Bihar 4.8 Bihar's 16.9% prenatal care rate is lower than Kerala's 93.9%.8 This explains why the two states differ in all health metrics. Bihar women had higher anemia rates than men. This shows state gender prejudice. Bihar has 59% domestic violence whereas Kerala has 16%. These are all reasons why a state where women are empowered and participate in society is doing better than others. To conclude, all governments should empower women since it is a cornerstone to state and national growth.

## HEALTHCARE IN ITS PROPER FORM

India's standardized medical facilities are extensive and varied. There is a wide variety of organizational structures and methods used to deliver healthcare in the nation. There are several manifestations of the biological paradigm's privileged status in American medical institutions. These approaches might be anything from textbooks that are sexist or insensitive to the attitudes of physicians who may not be aware of the underlying socioeconomic factors in illness. The gains made in the decades prior to the 1990s predominantly financed the growth of the public sector in terms of its physical footprint. Public healthcare facilities can range

from a small outpost in a remote area to large university medical centers in densely populated cities. Municipal Hospitals and Clinics are just two of the many public healthcare facilities available. Others include Primary Health Centers, Rural Hospitals, and Civil Hospitals. For the treatment of a specific disease or for a certain demographic grouping (for instance, the Central Government Health Scheme), the state may oversee specialized healthcare facilities like leprosy clinics. Thus, the public health sector's organizational architecture is quite well-defined. Community Health Centers (CHCs), Primary Health Centers (PHCs), and Subcenters (SCs) proliferated at variable and unequal rates across India's many states and union territories in the 1990s. There has been notable expansion of these types of facilities in some regions, while progress has been slow or stagnant others. There is a serious paucity of community health centers, one of the three types of public institutions designed to provide basic healthcare, in rural areas with large indigenous populations. This holds true across the board in the United States. With a few exceptions, all of the remaining states and union territories lack adequate levels of all three types of public conveniences.

**Table-2 Nutritional Status in Relation to the Gender 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 |

**Table-3 2008 Report on the Progress of Indian Women**

| **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 | 131 | 123 | 127 | 55 | 52 | 53 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Births | | | | | | |
| -Child Death Rate (2007) (0-4 years)<br>(2007) (5-14 years) | - | - | - | 16.9<br>1.2 | 15.2<br>1.1 | 16.0<br>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<br>(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 |

The private healthcare industry in this nation is expansive and diffuse, with a primary focus on providing curative care. In addition, the not-for-profit sector, which also encompasses the services provided by non-governmental organizations, can be found in many urban and rural locations around the nation. In the private sector, there is a great variety in the medical practices that are carried out, the types of ownership structures that are utilized (which can range from sole proprietorships to partnerships and corporate organizations), and the kinds of services that are made available. In addition to being present in towns and cities, the private sector may also be found in the majority of medium-sized to large villages. Nevertheless, most of the time, large urban regions are where you'll find institutions that have the most cutting-edge technology and provide a wide range of different specializations. The private sector is disproportionately concentrated in metropolitan regions both in terms of raw numbers and in terms of employment opportunities.

Numerous smaller studies and large-scale national surveys, such as the NSS and the NFHS, in addition to a number of other smaller research, have all found that the private sector is the predominant sector in healthcare. According to estimates from the 52nd round of the NSSO, which was conducted in the middle of the 1990s, the private sector is responsible for approximately 80% of non-hospitalized treatments in both rural and urban regions. These figures are an increase of 7-8 percentage points over the estimates provided by the 42nd round

of the NSSO, which was conducted in the middle of the 1980s (NSSO, 1998b). In contrast to the 1980s, when the public sector accounted for the majority of hospitalized treatments across the country in both rural and urban parts of the country (ibid), the private sector has overtaken the public sector as the dominant player in the provision of hospitalized treatment in the 1990s. When compared to the public sector, client satisfaction in the private sector is better along indicators such as the behavior of the employees, the amount of privacy provided, the amount of time spent, etc. In spite of its widespread presence and widespread appeal, the private healthcare industry in India is poorly regulated and works with little responsibility with respect to its actions6. Additionally, allegations of illogical practices and even malpractices are not unusual when leveled against the private sector in India. The high cost of treatment in the country's private health sector has been the subject of a significant number of research, both small-scale and large-scale macrostudies. These studies have found that the costs of treatment in the private health sector are frequently more than twice as high as those spent in the public health sector.

## CONCLUSION

One obstacle to women's empowerment is the lack of discretion women are afforded in many fields, especially those with far-reaching effects on development. Their limited literacy, media exposure, financial resources, and mobility all contribute to their institutionalized incapacity, which in turn limits their areas of competence and control (such as cooking). They tend to congregate among their own kind, however this is not always the case. However, gender norms have a significant impact on women's participation even in the domestic sphere. regarding half of all American women (51.6%, to be exact) take an active role in making choices regarding their personal healthcare. Women's health is significantly hampered by the widespread lack of knowledge about important topics among women. For instance, 60% of women who gave birth without seeking prenatal care during pregnancy reported that it was "not essential" to do so, as reported by the NFHS-2. In every instance, this was true. And even though the AIDS pandemic is feared to have reached pandemic proportions in the country, 60% of married women are unaware of the disease. Therefore, women's inferior standing lowers their access to medical care and negatively affects their health.

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