IJAER/ Jan-Feb 2023/Volume-12/Issue-1 ISSN: 2278-9677

International Journal of Arts & Education Research

A STUDY ON THE STATUS OF WOMEN HEALTH IN INDIA

Arshi

Research Scholar Department of Sociology

Meerut College, Meerut

University C.C.S.University Meerut (U.P.)

Prof. Amarjeet Singh Malik

Department of sociology

Meerut College, Meerut C.C.S University

Meerut (U.P.)

ABSTRACT

If health is defined "as a state of total physical, mental, and social well-being and not only the absence of sickness or infirmity," then it follows that existence is a required prerequisite for wanting to achieve the state of health. The safety of Indian girls is becoming an increasingly pressing concern. The child sex ratio in the nation for children aged 0 to 4 years old has dropped at a startlingly rapid rate over the last several decades. It has become common practise in India to terminate female foetuses by abusing the availability of technology improvements like ultrasonography and the country's comparatively lax abortion legislation. In 1991, there were 958 more females than there were boys per 1000, but by 2001, that ratio had dropped to 934 girls for every 1000 boys. There are less than 900 females for every 1000 boys in a number of states located in the western and northwestern regions of India. In states like Punjab, Haryana, Himachal Pradesh, and Gujarat, where extreme forms of isolation and hardship are prevalent, the sex ratio is at its absolute worst. Gujarat is the state with the highest rate of child marriage. Sometimes in adjacent regions in these states, the ratio drops to an alarmingly low level, falling below 800 girls for every 1000 males (RGI, MOHFW, UNFPA, 2003). According to the census completed in 2001, the information shown in Annexure I details the child gender distribution in each of India's states and union territories. The present study investigates the relationship between nutrition and the health of Indian women.

Keywords: *women, health, nutrients*

INTRODUCTION

There is a direct correlation between the social position of Indian women and their overall health. The contributions that Indian women make to their families are often disregarded in favour of the perception that they are a financial burden on their families, according to the findings of research on the status of women. In India, there is a significant desire for having boys rather than daughters since males are expected to take care of their ageing parents. Sometimes, as a consequence of this predilection for sons as well as the hefty dowry payments associated with females, the daughters end up being mistreated. In addition, there is a large gap between the educational attainment of Indian women and their engagement in the official labour sector. In most cases, they have very limited freedom of action since they are subject to the authority of their dads, then their spouses, and lastly their children1. The current state of Indian women's health is adversely affected by

each and every one of these concerns.

Not only do women themselves suffer the consequences of poor health, but so do their families. Women who are not in good health have a higher risk of having babies who are born with a low birth weight. They are also less likely to be able to provide food and proper care for their children, which increases the likelihood that the children would go hungry. Last but not least, the health of a woman has an effect on the financial stability of the home. This is because a woman who is not in good health will be less productive in the workforce. This profile focuses on just five critical topics, including reproductive health, violence against women, nutritional status, uneven treatment of girls and boys, and HIV/AIDS, despite the fact that women in India suffer a wide range of significant health difficulties. It should not come as a surprise that the cultural norms, religious practises, and socioeconomic standing of India's 25 states and 7 union territories are very different from one another; hence, the state-to-state disparities in women's health are not unexpected. When it is feasible to do so, statistics for the main states will be supplied in order to provide a more comprehensive view.

The treatment of female children unequally is so ubiquitous and systemic in this country that it may be seen in a wide variety of demographic statistics relating to the country. The incidence of death among female infants is much greater than the rate among male infants over the whole of the nation as well as in the rural parts of the country. The female newborn death rate tends to be greater in the northern and western states, however this is not always the case. A difference of 10 percentage points between the male and female rates of mortality is not an unusual occurrence in these regions. In the metropolitan parts of the nation, females have a very minor advantage over men when it comes to the risk of infant death (as a whole) However, metropolitan India is characterised by increased availability to abortion facilities, which means that undesirable female infants are often destroyed before they are born. In the context of the health of women, it has been suggested that long-term wellness may be achieved by the implementation of strategic interventions at key junctures in the relevant life phases. As a result, the life cycle approach promotes strategic interventions throughout critical phases such as early childhood, adolescence, and pregnancy. These treatments might take the form of anything from nutritional supplements to instruction on life skills. These types of treatments make an effort to disrupt the vicious cycle of poor health that may be passed down from generation to generation. The gender and age disparities in India's mortality statistics highlight the precarious position of Indian women throughout the formative stages of infancy, adolescence, and motherhood. This puts Indian women at a heightened risk for death. In this nation, a larger percentage of women than males pass away between the ages of infancy and the middle of their twenties. In rural areas of India, the mortality rate for women under the age of thirty is much higher.

The rules and ideals of patriarchy are firmly ingrained in Indian society, just as they are in the majority of other societies across the globe. Women's 'life chances' and their qualitatively inferior status in the various socio-economic spheres are both determined by patriarchy, which manifests itself in both the public and private spheres of women's lives in the country. Patriarchy exists in both the public and private lives of women in the country. It pervades organisations and institutions and works in a variety of covert ways to undermine the right of women to live dignified lives. As a result of their gendered existences, women share many of the same experiences throughout their lives. In a nation as large and socioculturally diverse as India, however, women's varied and often unique demands are enacted on a landscape that is variable according to age, caste, class, and area, resulting in a complexity of experiences. This is especially true for women's health care requirements. Caste and class are two examples of traditional foundations of social stratification that

continue to manifest themselves in women's lived experiences, as do rural-urban and regional differences. As women advance through the life cycle, they find that they have new requirements. Due to the complexity of the situation, it is difficult to have a conversation regarding women's health and access to medical treatment.

Women Health in India

The state of one's health is very nuanced and subject to influence from a variety of sources. The extensive and diverse effects that result from the interaction of social and environmental elements on one another have a direct bearing on health. The lived experiences that women have as gendered beings result in a variety of distinct, although highly linked, health demands. However, gender identities may be seen to be played out from a variety of locations and situations, such as caste and class. The numerous pressures of 'creation and reproduction' that come with being in a less advantageous position have significant repercussions for the health and happiness of women. This section on women's health in India organises the evidence that has already been collected on the subject. The many facets of women's health are organised into themes for the sake of presentation, but the topics should not be interpreted as mutually exclusive and airtight containers. There are several ways in which the circumstances of women's life influence the state of their health.

1999 was the year when the world's population passed the 6-billion mark, while India's population reached same milestone the next year. The population of India is anticipated to reach close to 1.2 billion in the year 2011. Some metrics of quality of life in Asian nations, including India, have improved over the years, such as life expectancy, literacy, and infant mortality; however, other indicators, such as environmental sanitation and environmental degradation, have remained stagnant or worsened. The tables that follow include international comparisons on a few of the indicators of human development for Asian nations as well as indicators for various states in India. The tables also provide international comparisons for India.

Nutrition

The state of one's health may be influenced by their diet. The body's resistance to infection is increased by eating a diet that is nutritionally balanced, which not only helps the body fight off diseases that it now has but also protects it from getting further infections in the future. Depending on the nutrient that is being discussed, nutritional efficiency may present itself in a variety of different forms, such as protein and energy malnutrition, night blindness, and iodine deficient forms, anaemia, stunting, low Body Mass Index, and low birth weight. Inadequate dietary consumption is also a contributing factor in the development of other diseases, including coronary heart disease, hypertension, non-insulin-dependent diabetic mellitus, and cancer, to name a few. In the nations of south east Asia, nutritional deficiency illnesses of many forms are extensively widespread. However, specific pockets of the region indicate an infelicity in the prevalence of particular types of disorders. Iodine deficiency illness is endemic to the Himalayan region as well as various other tribal regions, and anaemia is a prevalent condition throughout the majority of the country's socio-economic categories.

Table 1 Human Development Indicators for SAARC Countries and Selected Asian Countries

Country	xpectancy at Birth(years)	Infant Mortality Rate (Per thousand live	Adult Literacy Rate (%) (age 15 years & above)

		Births)	
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.

In this respect, the state of Maharashtra in western India serves as a paradigmatic example due to the fact that economic development on its own is insufficient to guarantee that a people would have a healthy nutritional status. Despite having one of the lowest nutritional profiles of any state in the nation, Maharashtra has one of the highest per capita earnings in the country of all the states in the country. More than half of the families in the state's urban and rural regions get less than the recommended appropriate quantity of calorific intake, and the situation has become more dire in the state's rural areas over the course of the last twenty years. Academics and others responsible for formulating public policy in India have been paying attention to the nutritional condition of children and women in the country for some decades now. In spite of the attention, some subsets of the population continue to be in a nutritionally deficient state. The female child is at a disadvantage from birth (or even before it) owing to her sex, and as a result, she is often refused access to the little food resources that are available within the home, or her access to those resources is severely restricted. A recent study that was conducted in three underdeveloped districts of the state of Maharashtra found that in the project areas of the Integrated Child Development Services (ICDS), which is a state-run programme that is intended to improve the nutritional status of children as well as pregnant and nursing women with the assistance of supplementary nutrition, the girl beneficiaries consistently showed poorer weight for age results when compared to the boy beneficiaries. This was in comparison to the results that were obtained by the boy beneficiaries.

This was the case for all three of the age groups that were specified for the project: children with ages below one year, children with ages between one and three years, and children with ages between three and six years. All three districts of Jalna, Yawatmal, and Nandurbar demonstrated similar coherence over the whole region. Jalna is the most non-tribal of the three districts, whereas Yawatmal is a district with a population that is composed of both tribal and non-tribal people. There is a significant culture divide between the three districts. The majority of the people living in the Nandurbar district are of tribal descent. According to estimations obtained at the national level from the NFHS-2, females had a much higher risk of being undernourished or even seriously undernourished, as measured by the indicators of weight for age and height table 2. As a result, underweight and stunted growth affect more females than boys. In terms of weight in relation to height, boys have a slightly greater risk of showing signs of undernourishment and severe undernourishment than girls do; in other words, boys are more likely to be underweight than girls. The anatomical and physiological make-up of women need the use of specialised dietary supplements. Both menstruation and delivery are physiological events that deplete iron stores in the body. As a preventative measure against osteoporosis in later years, a woman has to take calcium supplements on a consistent basis throughout her life cycle. The diet of Indians, which is mostly vegetarian, does not provide enough of several nutrients for them to meet their needs. In addition, women are put at a disadvantage by cultural traditions, which contributes to their already low nutritional health. It is common practise in many homes throughout the nation for the women to wait until the men have finished eating before sitting down to their meals, at which point they consume any leftovers..

Formal healthcare

The country of India has a sizable and varied formal healthcare infrastructure. The providing of healthcare in the nation is characterised by both a sectoral and a functional diversity of approaches. The privileging of the biomedical model in medical colleges across the country reflects itself in a variety of ways. These ways range from textbooks that are frequently gender blind or insensitive to the attitudes of providers, which may display a lack of understanding of the socioeconomic causes that lie behind ill health. Gains that were gained in the decades leading up to the 1990s primarily contributed to the expansion of the size and scope of the public sector's physical presence. The infrastructure for public healthcare may vary from a sub-center in a rural location to hospitals with many specialties and multiple beds in metropolitan areas. Some of the other public healthcare institutions are Primary Health Centers, Rural Hospitals, and Civil Hospitals, in addition to a multitude of other facilities such as municipal Hospitals and Clinics. Additionally, the state may be responsible for the operation of health care facilities that are devoted to treating certain illnesses (like leprosy clinics, for instance) or particular segments of the population (for instance, Central Government Health Scheme). Therefore, the organisational framework of the public health sector is rather clearly established. Across the 1990s, the number of Community Health Centres (CHCs), Primary Health Centres (PHCs), and Sub-centers (SCs) in India's various states and union territories grew at varying rates and rates of unevenness.

In certain areas there has been a significant growth in the number of such facilities, while in others either very little progress has been made or the number has remained the same. The three different kinds of public institutions that are set up for delivering basic healthcare are lacking in tribal regions, with the lack of community health centres being particularly severe. This is the case for the nation as a whole. All other states and union territories, with a few notable exceptions, suffer from a lack of development in all three categories of public infrastructure.

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

Source: NFSH2, *Note:* The indices are presented using the standard deviation units (SD) as a measure of their distance from the median value of the International Reference Population. • Takes into account youngsters who fall at least three standard deviations below the international reference population's median.

Table 3 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 Births	131	123	127	55	52	53
-Child Death Rate (2007) (0-4 years)	-	-	-	16.9	15.2	16.0

(2007) (5-14 years)				1.2	1.1	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

The private medical industry in this nation is massive and diffuse, with a primary focus on providing curative treatment for patients. In addition, the not-for-profit sector, which also encompasses the services provided by non-governmental organisations, can be found in many urban and rural locations around the nation. In the private sector, there is a great variety in the medical practises that are carried out, the types of ownership structures that are used (which may range from sole proprietorships to partnerships and corporate organisations), and the types of services that are provided. 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 metropolitan regions are where you'll find institutions that have the most cutting-edge technology and provide a wide range of different specialisations. 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, as well as a number of other research, all indicate that the private sector is the predominant sector in the healthcare industry. 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 nearly 80% of non-hospitalized treatments in both rural and

urban areas.

These estimates are an increase of 7-8 percentage points from the estimates provided by the 42nd round of the NSSO, which was conducted in the middle of the 1980s (NSSO, 1998b). In the 1990s, the public sector has fallen behind the private sector when it comes to providing hospitalised treatments. This is in contrast to the 1980s, when the public sector was responsible for the majority of hospitalised treatments across the country, including those provided in both rural and urban areas (ibid). When compared to the public sector, client satisfaction in the private sector is better along indicators such as the behaviour of the employees, the amount of privacy provided, the amount of time spent, etc. The private healthcare sector in India is poorly regulated and operates with little accountability with respect to its actions6, despite the fact that it is widespread and popular. Allegations of irrational practises and even malpractices are not uncommon when levelled 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 studies, 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 incurred in the public health sector.

CONCLUSION

The lack of autonomy that women are allowed in many sectors, particularly those that have a significant impact on development, is a barrier to women's empowerment. Their low levels of literacy, limited exposure to mass media and access to money, and restricted mobility all contribute to their institutionalised incapacity, which in turn results in narrow areas of competence and control (for instance, cooking). They are more likely to be found inside their families, however this is not always the case. However, even in the context of the home, women's engagement is heavily influenced by gender norms and expectations. At the national level, about 51.6% of women are actively engaged in the decision-making process for their own healthcare.

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,

[3]. R. Beaglehole and H. Tanaka (eds.) *Oxford Textbook ofPublic Health* (fourth edition), New York: Oxford University Press, 149-170 (2004)

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

[5]. 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)

[6]. 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)

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

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

[9]. 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)