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SOCIO-ECONOMIC IMPACT ON THE WOMEN HEALTH IN INDIA
Issues, Challenges and the Way Forward

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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 orinfirmity', it follows that existence is a necessary condition for aspiring for health.The girl child in India is increasinglyunder threat. In recent decades, there has been an alarming decrease in the child sex ratio (0-4 years) in the country.Every day, approximately 1000 women die due to complications of pregnancy and childbirth — nearly allof these deaths are preventable.*

Indian urban women have come a long way regarding careers andsocial standing. However, they still remain unaware of their personal well-beingand health needs. Often, they ignore their health problems until the problemsbecome unavoidable, chronic or even fatal. The present paper focuses on thedeterminants of women's health in urban India. The paper also suggests somechanges required in policies for improving urban women's health in India.

Keywords: *Women, Health, Nutrition.*

1. 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. All of these factors exert a negative impact on the health status of Indian women.

2. WOMEN'S HEALTH IN INDIA

In India, gender-based health indicators have shown improvement over time, however, these developments are still far from optimal. In comparison to the

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European states, the difference in gender based indicators is enormous. For example, among cause-specific mortality rates, maternal mortality rate in India is 16.6 times, TB among the HIV positive population is 2.8 times, and age-standardized mortality rate from non-communicable diseases is 1.2 times the comparable rates in Europe. Only the incidence of cancer in India is significantly lower than in the EU (WHO, 2009).

3. SOCIO-CULTURAL & POLITICAL DETERMINANTS

Most women do not have autonomy in decision making in their personal lives. At the macro level, women are also under-represented in governance and other decision-making positions. In Madhya Pradesh and Rajasthan, less than 50% of women have any access to money in the household (IIPS & ORC Macro, 2000). Parents also discriminate against their female children through neglect during illness. When sick, little girls are not taken to the doctor as often as their brothers are. A study in Punjab showed that medical expenditures for boys are 2.3 times higher than for girls (Coonrod, 1998).

4. FORMAL HEALTHCARE

The formal healthcare setup in India is huge and diverse. Sectorial plurality and functional diversities mark theprovisioning 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.

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-governmentalorganizations) is alsopresent in many urban and rural areas of the

country. There isremarkable diversity in the private sector in terms of the systemsof medicine practiced, the type of ownership (ranging from soleproprietorship to partnerships and corporate entities), and theservices provided. The private sector has a presence in mostmedium to big villages as well as in towns and cities. However,facilities with technologically advanced equipment and offeringvaried specializations are almost always in the big urban areas.In terms of sheer numbers as well, the private sector isdisproportionately concentrated in the urban areas. Large scalenational surveys like the NSS and the NFHS, as well asnumerous smaller studies report that the private sector is thedominant sector in healthcare. The 52nd round of the NSSOcarried out in the mid-1990s estimates that the private sectoraccounts for nearly 80% of non-hospitalized treatments in bothrural and urban areas, up by 7-8 percentage points from theestimates of the 42nd NSSO round in the mid-1980s NSSO,1998. For hospitalized treatment, the public sector has lost outto the private sector in the 1990s, in contrast to the 1980s whenthe public sector accounted for the majority of the hospitalized treatments in both rural and urban areas of the country.Client satisfaction is higher in the private sector along indiceslike behavior of the staff, privacy accorded, amount of timespent, etc. Despite its ubiquity and appeal, the private healthcaresector in India is poorly regulated and operates with littleaccountability with respect to its actions. Allegations ofirrational practices and even malpractices are not uncommonagainst the private sector in India. A large number of studies(micro as well as large scale macro studies) have pointed out thehigh cost of treatment in the private health sector of the country,the costs being many a time more than double of that incurred inthe public sector.

5. INDIAN URBAN WOMEN'S MORBIDITY

The health of Indian women is linked to their status in society. The society is patriarchal, and there is a strong preference for sons in India. This bias sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. Typically, they have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons (Velkoff&Adlakha, 1998). To gain a better perspective on the health status of urban Indian women, it is important that we look at some of the selected diseases from which women frequently suffer, and compare them with the prevalence rates amongst their ruralcounterparts, and also compare them with men.

(a) Diabetes, Asthma & Goiter

In cases of diabetes, asthma and goiter, urban women do worse than their rural counterparts. Also, women suffer from goiter more than men, both in rural and urban areas, by about 1.93 and 3.62 times, respectively. Moreover, urban women suffer more from asthma than their male counterparts (Sengupta& Jena, 2009).

(b) Cancer

Though the incidence of cancer is still low in India compared to that of developed countries, incidence of breast and cervical cancer is becoming increasingly significant. According to the National Sample Survey (NSS, 2004), out of every 1000 women, 33 in urban areas and 39 in rural areas were hospitalized due to cancer. A recent survey done by WHO reveals that every year 132,082 women are diagnosed with cervical cancer and 74,118 die from the disease. In fact cervical cancer ranks as the most frequent cancer among women in India. (Are you putting yourself last, 2010).

(c) HIV/AIDS

Lack of gender-sensitive education is also leading to new infections such as HIV/ AIDS and other sexually transmitted diseases (Pramanik, Chartier&Koopman, 2006). HIV prevalence in India among adults is estimated at 0.8% (4.58 million) in 2002. Out of these, women constitute 25% of the reported cases. The spread of HIV infection is not uniform across the states. Six states, Andhra Pradesh, Karnataka,Nagaland, Manipur, Maharashtra and Tamil Nadu, have beencategorized as high prevalence states. Differences in power between men and women are a major cause of the spread of HIV/AIDS among women. Pressures of migration, violence against women including trafficking and domestic violence, are manifestations of this problem, which in turn, subject women to HIV/AIDS infection risk. Lack of information and denial of access to safe practices during sex are additional reasons for the current situation (Mitra, 2009). Also, inn general, Indian women have little power to negotiate the conditions of sex with their partners, both in and outside of marriage.

(d) Malnourishment

Undernourishment among women in India is high. In the Global Hunger index calculated by IFPRI (2008), India ranks 66thamong 88 ranks (higher numbers show hunger). India also scores 23.7 with an 'alarming' hunger incidence (Gandhi, 2009). Women's nutritional levels are lower than men since women face discrimination right from the time of breastfeeding to their adulthood (Pandey, 2009).

(e) Anemia

According to estimates, 25-30% of Indian women in the reproductive age group and almost 50% in the third trimester are anemic. One study found anemia in over 95% of girls aged 6-14 years in Calcutta, around 67% in the Hyderabad area, 73% in the New Delhi area, and about 18% in the Madras (Chennai) area. This study states, "The prevalence of anemia among women ages 15-24 years and 25-44 years follows similar patterns and levels" (Social empowerment, 2009). Anemia increases women's susceptibility to diseases such as tuberculosis and reduces the energy women have available for daily activities such as household chores and child care. In some states

such as West Bengal, Orissa, Bihar, Assam and Arunachal Pradesh, between 63 and 85% of married women suffer from anemia (IIPS & ORS Macro, 2000).

6. INTER-STATE & REGIONAL VARIATIONS IN URBAN WOMEN'S HEALTH

There are wide variations among cultures, religions and levels of development among India's 29 states and 07 union territories. Hence, women's health also varies greatly from state to state (Chatterjee, 1990; Desai, 1994; Horowitz &Kishwar, 1985; The World Bank, 1996). India is a massive country in terms of its diversity and cultural practices. Availability and utilization of reproductive and child health services from state to state widely differ. It is essential to understand the extent of poor and non-poor disparities in urban areas across the states irrespective of their urban poverty (Kumar &Mohanty, 2010). Son preference is very strong in states like Uttar Pradesh, Bihar and Rajasthan, which leads to larger families as couples continue to have children until they reach their desired number of sons (Singh, 2003). Inthe state of Haryana, the sex ratio in the 0-6 year group hit a five yearlow of 830 girls for 1000 boys (Census, 2011). Traditionally a patriarchal region, the gender skew in Haryana can be attributed to a strong son preference. Moreover, families misuse and abuse new reproductive technologies to get rid of female pregnancies (Rustagi, 2006; Sev'er, 2008). Haryana is only one of many Indian states to grapple with the menace of female foeticide. Several socio-cultural factors such as landholding patterns, inheritance norms and dowry have tilted the scales against the girl child (Times of India, 2010). Existing empirical literature on inter-state or regional patterns of gender bias shows girls to be more likely to be malnourished than boys in both northern and southern states (Patra, 2008). "The states with strong anti-female bias include rich ones (Punjab and Haryana) as well as poor (Madhya Pradesh and Uttar Pradesh), and fast-growing states (Gujarat and Maharashtra) as well as growth-failures (Bihar and Uttar Pradesh)" (Sen, 2005, p. 230). The north-western parts of the country are known for highly unequal gender relations. Symptoms of this inequality include thecontinued practice of female seclusion, very low female labor forceparticipation rates, a large gender gap in literacy rates, extremelyrestricted female property rights, a strong preference for boys in fertilitydecisions, neglect of female children, and a drastic separation of marriedwomen from the natal family (Dreze & Sen, 1995).

There are multiple cultural barriers and social evils that influence health which operate at the household and individual levels. These relate to class, caste, ethnicity, religion and gender inequalities. Gender issues are especially important and in India, women and girls face severe discrimination in personal rights (e.g. sexual and reproductive choices) and access to personal services such as education, health facilities and family planning services (Luce, 2006). The intra household inequalities and discrimination impact the status of women. For example, in tribal societies in India that have a very high incidence ofpoverty, women enjoy higher social status than their counterparts in other regional groups. However, because of the overall socio-economic position of tribal groups in the larger society, they are still more vulnerable

to discrimination and violence perpetrated by those belonging to non-tribal groups (Thukral, 2002). It is clear that national averages of health indices hide wide disparities inpublic health facilities and health standards in different parts of thecountry. The wide inter-state disparity implies that, for vulnerablesections of society in several states, access to public health services isnominal and health standards are grossly inadequate (NationalPopulation Policy (NPP), 2002).

7. QUALITY OF HEALTH SERVICES

Women's health is also harmed by the poor quality of reproductive services. "About 24.6 million couples, representing roughly 18% of all married women, want no more children but are not using contraception" (Anand, 2005). The causes of this unmet need remain poorly understood, but a qualitative study in Tamil Nadu suggests that women's lack of decision-making power in the family, women's lack of control over sexual/reproductive choices, opportunity costs involved in seeking contraception, fear of child death, and poor quality of contraceptive service, all play an important role" (Kumar and Mitra, 2004).

8. POLICY SUGGESTIONS

According to Sally Thorne, "what counts as knowledge is being re-defined in terms of capacity to influence policy" (Thorne, 2001).Therefore, the need to generate such knowledge as would bring a change in the way policies are formulated. Economic growth needs to be followed with progress on family health and female education, to full-fill the millennium development goals (MDGs). In order to ensure that public money is spent properly, civil society groups and local communities will be required to play a larger and a more meaningful role. The following are some policy suggestions to improve the health status of urban Indian women:

(***a) Empowerment Measures:*** The Colombo Call for Action (WHO, 2009), acknowledged some steps taken by individual countries such as the contributory social security system for self-employed women in India.Contributing to the empowerment of individuals, in particular women and vulnerable groups, the following were suggested: employmentgeneration, giving access to finances and skill improvement,improvements in societal conditions, scaling-up country specific innovations that successfully address health inequities through a social determinants approach, sharing lessons across countries in the region,and establishment of national institutional mechanisms to coordinate and manage inter-sectoral action for health in order to mainstream health equity in all policies, and where appropriate, using health and health equity impact assessment tools (WHO, 2009). The need to put more vigor into programs like the one started with the assistance of UNICEF, a centrally sponsored program of Urban Basic Services, was introduced in 1986, to provide basic social services and physical amenities in urban slums. It was started with a view to bring together health, education, social welfare and industry/ industrial training in urban

slums, while focusing on child and women's survival and development through immunization, nutrition supplementation, provision of preschool and crèche facilities and training for income generation in relation to social services. It also aimed at the provision of basic physical facilities such as water supply, drainage and low cost sanitation in relation to physical services. The program emphasizedcommunity based management through neighborhood committees ofthe urban poor themselves (UNICEF, 1993).

(***b) Improving Living Conditions:*** A scheme called Environmental Improvement of Urban Slums (EIUS) aims at ameliorating the living conditions of urban slum dwellers and envisions provision of drinkingwater, drainage, community baths, community latrines, widening and paving of existing lanes, street lighting and other community facilities (Urban Poverty Alleviation Programs, 1993-1994).

Other issues that need focus are related to at least two broad areas. First, improving the access and availability of basic amenities and public provisioning related to water, fuel, toilets and sanitation, electricity and so on, in order to improve the conditions of living and well-being of poor women. Second, addressing factors involving external environment such as shelter spaces, transport, overall security levels that can improve the standards of living for poor women. Also, facilitation of their participation in the urban labour market is recommended (Rustagi Sarkar & Joddar, 2009).

It has been suggested that 2-3% of the GDP be allocated towards health services, and essential drugs be made available free of charge, through a strong, accountable and sensitive health-care system. There is a need to specify clear indicators in order to monitor the health system.

(***c) Popularizing Regular Medical Checkups:*** Regular and thorough medical check-ups of urban women need to be popularized through awareness campaigns. Working women should be given off-time, withoutsacrificing their pay, for regularly consulting their doctors regarding their health. Lifestyle coaching for women in schools, colleges, work places, and at community meetings need to be organized to create health consciousness at all levels.

(***d) Cluster Services & Child Care Centers:*** The importance of creating an enabling environment for women and children to benefit from products and services disseminated under the reproductive and child health programs should be realized. This can be achieved by creating cluster services for women and children at the same place and time. This will promote positive interactions in health benefits and may reduce service delivery costs (Tinker, Finn & Epp, 2000).

It has been suggested that more child care centers be opened in urban slums, where women workers can leave their children in a safe environment. Access to child care can also stimulate female participation in paid employment, help reduce school drop-out rates of girls who serve as baby-sitters, and promote school enrolment as well. The anganwadis (the government run crèche at community level) in India area partial

solution, but the quality of their operations needs to beenhanced and standardized. Also, making quality maternal and childhealth services accessible to all women through cluster services forwomen and children at the same place and time is crucial. Services thatcan be clustered are prenatal and post-partum care, monitoring infantgrowth, availability of contraceptives and medicine kits, and routineimmunizations. Life-saving skills training of birth attendants andcommunity midwives at district-level hospitals as well as managementof asphyxia and hypothermia are important. Also needed is theintegrated management of childhood illnesses for infants (NationalPopulation Policy, 2000).

(***e) Elimination of Gender Disparities:*** Utmost importance must be given to the elimination of gender-related health inequities in order to balance the social determinants of health. Improvement of health informationsystems and building research capacity in order to monitor and measure the health of national populations are also crucial. Work needs to progress regardless of age, gender, ethnicity, race, caste, occupation, education, income and employment, where national laws and context permit (WHO, 2009).

The experience of states where the total fertility rate of 2.1 has been achieved, has demonstrated that different approaches have to be adopted in different situations. Goa, the first administrative unit to achieve the replacement level of fertility, achieved it with high literacy and good health care infrastructure. In Kerala, the first state to achieve replacement level of fertility, the factors that helped were high status of women, female literacy, later ages at marriage and low infant mortality. Tamil Nadu which was the second state to achieve replacement level of fertility did so because of the strong social and political commitment, backed by good administrative support and availability of family welfare services. Andhra Pradesh could achieve replacement level of fertility, in spite of relatively lower age at marriage and low literacy (Singh, 2003).

The system of medical education needs to sensitize the students to expecting gender variance in their practice of medicine in various disciplines like surgery, pediatrics, gynecology, psychiatry, etc. This recommendation needs to be incorporated at all levels of the policy and implementation mechanisms (Krasnoff, 2000).

(***f) Bringing Convergence:*** Bringing convergence, strengthening, and universalization of the nutritional program of the Department of Family Welfare and the Integrated Child Development Services (ICDS) run by the Department of Women and Child Development, needs proper references is necessary. Also, ensuring training and timely supply offood and medicines, including STD/RTI(Sexually Transmitted Diseases/ Reproductory Tract Infections) and HIV/AIDS prevention, screening and management in maternal and child health services are needed services. Other important services include the provision of quality care in family planning, including information, increased contraceptive choices and methods, increased access to quality and affordable contraceptive supplies and services at diverse delivery points, counseling about the

safety, efficacy and possible side effects of each method, and appropriate follow-up. Developing a health package for adolescents is also important (Mishra, 2000).

(***g) Access to Safe & Legal Abortions:*** In affluent states where dissemination of both contraceptive information and contraceptives has been established, abortion becomes a rarely utilized final option in terminating unwanted pregnancies. However, and unfortunately, in the developing regions of the world, abortion is still a frequently utilized form of birth control. So, there remains a need for making safe and legal abortion services available to women and household decision makers by 1) increasing geographic spread; 2) enhancing affordability; 3) ensuring confidentiality; and 4) providing compassionate abortion care, including post-abortion counseling. Modifying the syllabus and curricula for medical graduates in these matters is necessary, as well as enhancing continuing education in newer procedures (Kapilashrami et al., 2004). Developing maternity hospitals at sub-district levels and at community health centers to function as 'first referral units' for complicated and life-threatening deliveries will reduce additional risks for women (National Population Policy, 2000).

(***h) Redefining Standards:*** It is important to formulate and enforce standards for clinical services in the public, private, and NGO sectors. Focus on distribution of non-clinical methods of contraception (condoms and oral contraceptive pills) through free supply, social marketing as well as commercial sales must be given priority (National Population Policy, 2001).

(***i) Multi-Pronged Strategy:*** A multi-pronged strategy to improve the health of Indian women is needed. Free education for girls and other forms of government support have helped the states to achieve one of the healthiest sex ratios in the country. The 'Ladli' scheme of the Delhiand 'LadliLaxmiYojna' MP government, which provides financial support to girls of poor families, isanother positive move. Efforts should also be made to rope in community leaders. The role being played by Gurudwaras (place of worship in the Sikh religion) in Punjab in campaigning against femalefoeticide is a good example. Economic empowerment of women combined with cultural and community initiatives are the answer to society's alarming gender skew (Times of India, 2010).

The *Sarva Shiksha Abhiyhan* programme for universalization of primary education and the *Mahila Samakhya* programme which has set up alternative learning centres for teaching empowering skills to girls from disadvantaged communities are among the major initiatives of the Indian government to improve literacy levels (UNICEF, 2007).

(***j) Networking:*** The National Population Policy, 2000, suggested, "Create a national network consisting of public, private and NGO centers, identified by a common logo, for delivering reproductive and child health services free to any client. The provider will be compensated for the service provided, on the basis of a coupon, duly counter-signed by the beneficiary, and paid for by a system to be devised. The compensation will be identical to providers across all sectors. The end-userwill choose the provider of the service. A group of management experts will devise checks and balances to

prevent misuse" (India-National Population Policy, 2000). States should incorporate initiatives for urban health needs in their program/implementation plans. The WHO, the Indian government and health/municipal authorities, women's organizations, the NGOs, and the community groups need to work in tandem. More importantly, men and women need to become aware of the equality of sexes and need to respect the same. Both sexes need to learn how to live in co-operation and harmony, which is often difficult to secure in traditionally very patriarchal parts of the world.

Since healthy mind lives in healthy body so a women with good health can contributes better in all fieldsof life including science and technology.

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