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An issue of women and health with reference to India

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ABSTRACT: Wellbeing *or health is the intensity of metabolic competence of a living being. If we firmly define health as a condition of whole bodily, cerebral and societal comfort and not just the nonexistence of disorder or disease, then it can be said that survival is an essential stipulation for health. The female child in India is progressively more under risk. As per recent reports, there has been a shocking decline in the child sex ratio (0-4 years) in India. Because of admittance to technological advances of sonography and India's comparatively noninterventionist laws on abortion have been misrepresented to do away with female fetuses.The ratio of girl: boy has reduced from 958 girls to every 1000 boys in 1991, to 934 girls to 1000 boys in 2001. In many states of western and north western India, the ratio depicts even more pathetic story. There are as less as 900 girls to 1000 boys or even lesser.The sex ratio is at its most terrible situation in the states of Himachal Pradesh, Punjab and Haryana, where brutal practices of isolation and dispossession exist. Often in neighboring areas in these states, the proportion gets even below 800 girls to every 1000 boys (RGI, MOHFW, UNFPA, 2003).*
Keeping all the above factors in mind, the present paper analyzes the nourishment and women's wellbeing in India.

KEYWORDS: *Sex Ratio, Women, well being, Nourishment.*

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I. INTRODUCTION

The wellbeing of Indian women is essentially connected to their standing in civilization. Many researches on women's standing has brought into being that the inputs Indian women provide to families are often unnoticed, and as an alternative they are viewed as economic encumbers. India is a country which has a strong preference of a male child, as they are expected to take care for their parents as they grow old. This male child inclination, demand of huge amount of dowry for daughter's wedding, at times results in the mistreatment with girl child.

As on addition to this, Indian women have poor levels of education and labor force contribution. They usually have minute independence; first they are under the control of their biological parents, then they are under the control of their in-laws, and finally their male child. All such forceful factors put forth a depressing collision on the health condition of Indian women.

Reason for low weight infants is basically poor health of women. This also creates a problem of providing food and adequate care for their children. Lastly, a woman's well-being influences the domestic economic well-being; this is because woman not in good health will be less prolific in the labor force.

Whilst women in our country counter face many grave health problems, our paper focuses on five major issues: reproductive health, cruelty against women, nutritional position, imbalanced treatment of males and females, and HIV/AIDS. Since, there is ample discrepancy in ethnicity, religions, and levels of growth among India's 29 states and 7 union territories; this is also worth noting that women's health shows a discrepancy in every state. Be it a rural or an urban area, the infant mortality rate is higher for females in contrast to that for males. Typically, it is in the states of northern and western region that the female infant mortality rates are elevated. In the urban areas of India, the infant mortality rate is bit in favour of females. But, urban region has also been detected by access to abortions and also abortion of unwanted girl children before birth. The defenselessness of females in India in the essential periods of their babyhood, teenage years and childbearing is drawn attention by India's sex wise age specific mortality rates. The statistical records say that from infancy till the late twenties, higher percentage of women than men die in the country. As in the case of rural India, higher percentage of women dies at less than thirty years of age. Like most cultures across the world, Indian society has deeply entrenched patriarchal norms and values. Patriarchy is 'a system of society or government in which the father or eldest male is head of the family and descent is reckoned through the male line'. This evident itself in both the public and private spheres of women's lives in the country, which shows the probability of their living a life, i.e., 'life chances' and resulting in their quality wise inferior status in the diverse socio-economic orbs. It infuses institutions and organizations in a lot of menacing ways to demoralize women's right to venerable lives.

Emergence of facilities to provide for the new needs is the need of the hour as women progress through the life cycle. The major challenge is talking about women's health and access to healthcare in such a complex setup. The paper standardizes existing substantiation on the topic.

The population of the world crossed 7 billion in 2011, and in 2015, India's population is 1.311 billion. The eminence of life in Asian countries, including India have improved over the years such as life expectancy, literacy, infant mortality, etc, while others have remained stagnant or even depreciates such as ecological cleanliness and ecological dilapidation. HDI Ranks and Values of SAARC Countries are given in the tables below.

Table 1 HDI Ranks and Values of SAARC Countries

4 Highest HDIs		
Rank	**Country**	**HDI**
High human development		
1	Sri Lanka	0.750
Medium human development		
2	Maldives	0.698
3	India	0.586
4	Bhutan	0.584
4 Lowest HDIs Rank		
Low human development		
1	Afghanistan	0.468
2	Pakistan	0.537
3	Nepal	0.540
Medium human development		
4	Bangladesh	0.558

Source: UNDP, Human Development Report 2014.

Table 2 Indicators of Human Development for SAARC Countries and Some Asian Countries, 2008

S.N.	Country	Life Expectancy at Birth (years)	Infant Mortality Rate (Per thousand live Births)	Adult Literacy Rate (%) (age 15 years & above)
1	India	64	54	66
	Bangladesh	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.

Nutrition level of a female

Nourishment is a main factor of health. A human body can increase its resistance to infection by a healthy balanced diet, thus dividing off a host of infections and also helping the body battle up existing infectivity. Now depending on the nutrient in query, nutritional effectiveness can be noticeable in an arrangement of its orders for example protein vigor, undernourishment, night blindness, and iodine scarcity, anemia, low BMI and low weight at the time of birth. Inappropriate nutritional eating and drinking is also accountable for in cases like coronary heart disease, hypertension, blood pressure, non-insulin dependent diabetes, mellitus, etc. Dietary insufficiency disorders of diverse types are extensively ubiquitous in the countries of south East Asia, with some sacks showing inappropriateness in some types of disarrays.

Nutritional position

	Weight for age		Height for age		Weight for height	
Sex (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

Indian Women Health

Health is multifaceted and reliant on a congregation of factors. The vibrant interaction of societal and ecological factors has insightful and versatile insinuations on wellbeing. Practices lived by women as gender being the consequence in numerous and, considerably, interconnected health needs. However sexual category 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 table 2, given above.

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 years3 . 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. 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.

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 Subcenters (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.

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 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
• Organized Sector (No. in lakhs in 1971 & 2006)	19.3 (11%)	155.6	174.9	51.21 (19%)	218.72	269.93
• Public Sector (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

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The health sectors in India which are private are huge and unstructured, and predominantly occupied in therapeutic care. The not-for-profit sector like non-governmental organizations (NGOs) is also at hand in numerous urban and rural areas. There is noteworthy multiplicity in the private sector especially in the systems of drug practiced, the type of possession like sole proprietorship, partnerships and corporate entities, and the services provided. We can practically find the private sector in nearly all medium to large villages along with towns and cities. On the other hand, facilities with scientifically advanced apparatus and contributing wide-ranging specializations are mostly found in the big urban areas. If we talk about absolute numbers additionally, the private sector is inexplicably concerted in the urban areas. NSS, NFHS, and many other large scale national surveys and abundant smaller studies account that the private sector is the prevailing segment 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-hospitalized 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, 1998". For treatment after being hospitalized, the public sector was far away from the private sector in the 1990s, on the contrary, to the 1980s when the public

sector accounted for the majority of the hospitalized treatments in both rural and urban areas of the country (ibid).

Patron contentment is elevated in the private sector along indices like performance of the staff, solitude accorded, quantity of time used up, ambience, etc. Notwithstanding its ambiguity and plea, the private healthcare segment in India is inadequately synchronized and operates with modest responsibility and with respect to its actions. Accusations of illogical practices and even unprofessional conduct are not uncommon alongside the private sector in India. A large number of studies including micro as well as macro studies have pointed out the expensive treatment in the private health sector of the country, the costs are more than double of that incurred in the public sector.

II. CONCLUSION

Women's empowerment is stalled by inadequate self-sufficiency in many areas that has a sturdy comportment on enlargement. Their institutionalized powerlessness due to near to the ground levels of literacy, restricted revelation to media and access to currency and constrained mobility has resulted into limited areas of competence and control for instance, work related to housekeeping, cooking, etc. The family unit is the most important, if not the only central point for them. On the other hand, still in the domestic sphere of influence, women's contribution is exceedingly gendered. On a national scale, near about 51.6% of the women are implicated in pronouncement making on their healthcare. Women's extensive lack of knowledge about issues related to their wellbeing facades a grave hindrance to their being healthy. The reports show that out of the total number of births where no antenatal care was required during pregnancy, in 60 percent of the cases women felt it was 'not necessary and not important'. And, during a time period when AIDS is believed to have assumed virulent disease magnitude in the country, 60 percent of the married women have never heard of the ailment. Women's substandard status thus has poisonous effects on their health and limits their admittance to healthcare. The family circle has been seen to be a high-flying position for gender based prejudice in matters of healthcare in many other studies also. Marriage in India is predominantly patrilocal which means a pattern of marriage in which the couple settles in the husband's home or community. Premature marriage usually follows a condensed tutoring, disadvantaging girls in so many different ways. Women and health are the most important aspects of any country. India has taken initiation on "Beti Padhao aur Beti Bachao abhiyan", this is majorly to help the females in educating themselves and in turn they can help themselves to achieve success by maintain their dignity and health.

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