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ADDRESSING WOMEN'S RIGHT TO HEALTH IN INDIA: ISSUES AND CONCERNS

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ABSTRACT

The health of an individual is a complex phenomenon which is determined to a large extent by social and environmental factors. Hence the health of Indian women is essentially linked to the discrimination that exists in Indian society which permeates to the household. The paper is an understanding of the various health concerns that arise in the life cycle of a woman and the various policies that have been taken in this respect. The various issues of women's health in India on the basis of different parameters like demographic position, nutritional status and economic and socio-cultural aspects have been analysed here to address the issue of women's right to health in India.

Keywords: **Right to health, women's health, nutrition, health policies**

I. INTRODUCTION

The understanding of women's health is intrinsically connected with the idea of fundamental right to equality and it is important, health policy makers respond to gender concerns throughout the life cycle of women. In India, policies on women's health have been a neglected area of policy research and have been narrowly identified with reproductive health concerns. Even reproductive health concerns in health policy documents continue to focus on maternal and child health rather than a broad range of rights.

The patriarchal norms and values of the Indian society result in qualitatively inferior status of women in the society. In addition to this, in a vast and socio cultural heterogeneous country like India the lived experience of women's health varies with social stratification like caste and class as do rural urban dichotomy and regional disparities (**Misra 2006**).

Women's understanding of health is linked to how rights in other field like access to education, political participation of women, protection from violence and it encompasses the broad framework of right to equality and non-discrimination. Right from birth the health of the females in India during childhood, adolescence and child bearing is overlooked which is the main reason for skewed sex ratio in the country. Women have low access to education which reduces their participation in the formal labour force. The contributions that women make inside the house are often ignored and so is the health of the women. Though wide variations exist, in general women in India have limited freedom in decision making and access to money. These factors exert a negative impact on the health status of the women. Owing to this discrimination women report worse health conditions than men and require greater access to healthcare than men. Women with poor health result in poor families as ill health of the women has direct impact on the birth of a child. Such weak and undernourished infants face the challenge of survival and **(Bhutta et. al. 2008)** are a menace not only to the family but also to the labour force of the country.

II. REVIEW OF LITERATURE

The discussion on women's health in India arises from the fact that health requirements of men and women are not same. Numerous articles pertaining to status of women's health in India on various aspects like nutrition, maternal health, and socio economic status of women were consulted to gain conceptual understanding of the topic.

III. METHODOLOGY

The present work is based on secondary data from National Family Health Survey 5(NFHS 5)2019-21. Apart from this several books and journal articles have also been helpful in providing valuable information on this subject. Online platforms like Social Policy and Research, Pub Med, Hinari, Google Scholar and Med Ind, were done to obtain review literature on women's health in India.

IV. WOMEN'S HEALTH IN INDIA

Gender inequality in health has resulted in severe consequences for women and girls and women in India are victim of gender inequality right from birth (**Osmani, and Sen 2003; Sengupta, 2016).** Study shows that health outcomes are related to the concept of intersectionality i.e. poor health occurs when health intersects with other social stratification like class, caste, race, ethnicity, ability and gender among others. Therefore depriving women of good health in India has resulted in maternal mortality and morbidity, nutritional deficiencies have resulted in anaemia, HIV /AIDS and other sexually transmitted diseases and other acute and chronic conditions **(Sen and Ostlin 2007)**. Gender inequality in health not only affects the women but also has a negative impact on children during antenatal, perinatal and post natal periods. A cross national study of 138 countries show that positive correlation exists between Gender Inequality Index (GII) and neo natal, infant and under five mortality rates **(Brinda et al., 2015)**. In India women's health in policy documents have been myopic focussing only on maternal health. Government policies on health are still focussed on reproductive health concerns and control on women's fertility despite several other health issues like nutrition and sanitation which need programmatic interventions. Health policies and programmes need to connect issues of social and economic concerns in order to develop an all-inclusive understanding of the status of Indian women.

The next section of the article explores the issue of women's health in India on the basis of different parameters like demographic position, nutritional status and economic and socio-cultural aspects drawn from censuses, surveys and studies to throw light on the issue of right to equality and women's health.

V. DEMOGRAPHIC STATUS OF FEMALES

Gender composition is an important determinant for understanding the character of a given population. The female population in India stands at 58. 65 crore according to Census 2011. The sex ratio of India stands at 940 which was much lower than the global average sex ratio of 984 females per 1000 males as in 2010-11. The sex ratio in India has been adverse in terms of female in the post-independence period with the lowest at 930 in 1971 which remained low for two consecutive decades. A number of factors like child marriage, frequent and unnecessary child bearing, sex selective abortion and infanticide, preference of boys and neglect of girl babies are responsible for low sex ratio in India. NFHS 5 survey reveals that 23.3% of girls in were married before 18 years of age. Favourable sex ratio exists in states of Kerala (1084) Tamil Nadu (995) and Andhra Pradesh (992) and poor sex ratio is recorded in the state of Haryana (877), Jammu and Kashmir (883) and Sikkim (889)

The Census data on child sex ratio (0-6 age group) which was comparatively good till 1981(962 girls per 1000 boys) declined to 945 in 1991 Census, 927 in 2001 Census and down to 918 in 2011 Census. Poor child sex ratio indicates rampant abortion based on sex selection and sex determination using diagnostic techniques like ultra-sonography in urban and semi urban areas also in parts of rural areas. The lowest child sex ratio has been recorded in the states of Haryana (830) Punjab (846) and Jammu and Kashmir (859) **(Census 2011).**

Studies show dowry which is a long standing Indian custom of financial exchange between families during marriage specifically flowing from the bride's family to the bridegroom's family is a crucial factor causing foeticide, infanticide, sex selective abortions, biases in the upbringing of the girl child and child marriage which has produced a range of negative health outcomes for women (**Sethuraman et. al., 2006; Shah and Shah 2010; Mohindra, 2019).**

VI. NUTRITIONAL STATUS OF WOMEN

Nutrition is an important factor of good health. Nutritional deficiency can lead to a lot of health problems like anaemia, stunting, low birth weight and low Body Mass Index. In under developed countries nutritional deficit is a common amongst people and women in particular. Women require greater attention to nutrition owing to natural processes of menstruation and child birth Nutritional habits of women in India is heavily guided by social norms and practices. These include eating last and taking less, giving up on food when food is less to ensure that the husband, children or their in laws have enough. Protein rich foods are also lacking in their diets. The various social customs are not adjusted even during pregnancy and breast feeding when more nutrients are required. In some communities, pregnant women are encouraged to eat less to have easier deliveries or fast for son which deprives them of essential nutrients like protein and iron also reduces calorie intake **(Narayanan et. al.,2019)**

Adults' nutritional status is determined by their Body Mass Index (BMI). Adults with a BMI of less than 18.5 have lower immunity to disease and are less productive, whereas those who are overweight experience various health issues. According to the NFHS 5, 18.7% of women had a BMI below normal, indicating a dietary insufficiency that was more prevalent in rural regions (21.2%). Thus, severe health issues related to anemia and malnutrition among women persist in India.

Iron needs rise during pregnancy, yet most Indian women do not get enough of it. According to NFHS 5, during the study, 57.2% of women in the 15–49 age range were anemic, compared to 53% of pregnant women in the same age range. Inadequate maternal nutrition is caused by a number of variables, including early marriage, conception before the age of 20, and a lack of information about self-care, although low purchasing capacity is one of the main causes. Pregnancy-related poor nutrition raises the risk of low birth weight newborns. Low birth weight newborns start a genetically transmitted vicious cycle of stunting that results in short adults with tiny pelvic sizes, which increases delivery problems, mortality, and morbidity. **(Vir and Malik 2015).**

VII. SOCIO-CULTURAL ASPECTS

Women's empowerment and autonomy in decision making can bring about positive change and improve women's health and access to healthcare. In decision making process, women remain marginalized and this has an adverse impact on their societal status The NFHS 5 survey reveals women's role in decision making is only 88.7 % while a women having a mobile phone which they use is 54 %; 69.4 % urban and 46.6 % rural. Owing a house (jointly or alone) and having a bank or savings account is also significantly low. These selective aspects broadly reflect the basic conditions of life and survival of women which are interrelated with health and rights profile of women.

VIII. CONCLUSION

Given the fact that health needs of men and women are different, it is imperative to acknowledge the gender concerns in the life cycle of women for making policies. Over the years few policies and programmatic interventions have looked into women's health issues. The National Rural Health Mission initiated in 2005 emphasized the execution of a comprehensive rural health care which included reproductive health and family planning. Scheme for Adolescent Girls launched in 2010 provides nutritional and non-nutritional support to girls in the age group of 11-14 years. The flagship programme of Beti Bachao Beti Padao in 2015 has focussed on life cycle approach to the issue. The Pradhan Mantri Surakshit Matritva Abhiyan(PMSMA) and Pradhan Mantri Matru Vandna Yojna aims to increase institutional deliveries in order to reduce high levels of home deliveries and maternal deaths. Apart from these programmes, the National Health Policy 2017 aims to look after health needs of the women beyond the reproductive age group of forty years. The policy document also speaks of strengthening public hospitals 'more women friendly'.

Despite government interventions the statistical profile of women in India reveals that implementation of policies and programmes in health in India have lacked a holistic approach and establishing an integral link between women's right to health and their right to education, socio-economic equality and empowerment.

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