# WOMEN'S HEALTH STATUS AND THEIR ACCESS TO HEALTH CARE IN INDIA

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**Abstract**

*The health challenges that involve priority care are separate for males and females. In India, women's position in the society determines their health status.While the progress in the health facilities have promoted the women's approach to health care, but still the achievements are far less than the targets.The main objective of the paper is to analyse the health status of Indian women.The paper analyses that the Indian women are still facing tribulations regarding their health. They are not physically fit, mentally alert and socially organised. They lack the basic health facilities which are a matter of concern. They have low nutritional levels which result in high maternal mortality ratios. They are not aware of the modern health services available for their better health. These health hazards of women must be reduced as soon as possible to ensure a well-developed society.Education and employment are the tools which serve as the solution to all the health problems of Indian women. Education will improve the health of women by curbing the social and cultural traditions and employment will increase the economic power of women which will in turn help them to take advantage of all health facilities.*

**Key Words-** Women, Health, Education, Employment, empowerment

**Introduction:** Every phase of the life cycle requires the better health status of the individuals. It is considered to be an important indicator of social and human development. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Mishra, 2006). Poor health not only limits the adequate human functioning, but it poses major challenges for the proper implementation of policies. The health challenges that involve priority care are separate for males and females. Adequate health status of women is indispensable for the welfare of the society as a whole. In India, women's position in the society determines their health status. They have subsidiary place in the society than the men and they remain under the burden of numerous social responsibilities and commitments. They tend to rely

on self-care, home remedies and traditional medical care as compared to men who receive more modern treatment (Thapan, 1997). The injustice faced by the Indian women since their childhood reveals their poor health and low nutritional level. Gender inequality in the context of access to health care is evident in every phase of their life. Thus, health has implications for the development of social status of Indian women in the perspective of gender disparities.

While the progress in health facilities have promoted the women's approach to health care, but still the achievements are far less than targets. The sex ratio has improved from 933 per 1000 males in 2001 to 940 per 1000 males in 2011 (Census of India, 2011), but the rate improvement is very low. In 2009, 57.7 per cent of women had received health treatment in the medical institutions during their deliveries and 17 per cent of them had received it from qualified personnel but still 25.1 per cent of the mothers had received medical treatment from the untrained personnel (Family Welfare Statistics, 2011). Though the life expectancy at birth is higher for girls than boys, this is the only indicator which shows the better performance of women than men. During 2005-06, there were only 27.1 per cent of women who were able to take their own decisions pertaining to their health care. Fifty five per cent of women are suffering from anaemia as against 24 per cent of men. The nutritional status of women is also not satisfactory as 36 per cent of women are thin and 13 per cent are overweight (NFHS, 2009). Thus, the women face discrimination in the context of health facilities which may be taken as a good example of gender disparities prevailing in India.

The women's access to health facilities is also related with their employment, literacy and income level. The society determines the woman's responsibility; education enhances her proficiency; wealth yields her prosperity and health manipulates her productivity. The Indian women have low levels of both education and formal labour force participation (Saha and Saha, 2010). Due to low educational levels, they have to struggle hard to enter into the labour markets. They have very less sovereignty which forces them to live under the command of their fathers, husbands and their sons. Their diminutive control over their earnings pushes them towards the social oppression. The traditional social norms always place the women on the secondary place due to which they face challenges prior to their birth. All these issues point towards the depressing health status of women. Education is likely to enhance women's

economic independence by equipping them with skills necessary to take advantage of paid employment opportunities (Gupta and Yesudian, 2006).

The various policy initiatives made at the international level for the empowerment of women include the Beijing Platform for Action, the Beijing +5 Declaration and Resolution, the Cairo Programme of Action, the Millennium Declaration and the Convention on the Elimination of all Forms of Discrimination against Women (Gupta and Yesudian, 2006). Realizing the extent of gender inequality throughout the world, the United Nations Development Fund for Women (UNIFEM) was established as a separate fund within United Nations Development Program (UNDP) in 1984 (Mahanta and Nayak, 2013). In India, the attention towards the women's health has achieved concern in 1994 since the United Nations Cairo Conference. Subsequently, the Beijing Conference (1995) established the importance of gender as a critical dimension of reproductive and women's health (Mathur, 2008). The concept of 'gender mainstreaming' was introduced to include the gender awareness in all the legal affairs during this conference and it was strengthened more in the follow-up Beijing +5 conference in 2000 (Mahanta and Nayak, 2013). To strengthen the condition of women, the Indian government adopted a target free approach in 1996 which included the Reproductive and Child Health Programme (October, 1997) and the National Population Policy (March, 2000). Also, in 2000, at the United Nations Millennium Declaration General Assembly, the eight Millennium Development Goals are identified to be achieved by the year 2015 and one of these is promoting gender equality (Gupta and Yesudian, 2006). Despite all these efforts made at the international and the national level, the health status of Indian women is not given due importance and they face many difficulties in the access to health care. Therefore, strategic interventions at critical stages must be made for the development of health status of women in India.

## Objectives and methodology:

The main objective of the paper is to analyse the health status of Indian women. The study takes into account the sex ratio, fertility and mortality rates, life expectancy, reproductive health and access to health care among the Indian women. These issues are used to reveal the pattern of social development of the Indian economy. The causes of poor health status of Indian women are examined. Lastly, some suggestions and policy recommendations are given

to improve their health status in the society. The paper is based on secondary data. The data has been taken from National Family Health Survey, Family Welfare Statistics, NSSO, Sample Registration System and various journals.

## Sex Ratio in India:

Sex ratio is defined as the number of females per 1000 males in the population. This is an important social indicator to measure the extent of prevailing equity between males and females in a society at a given point of time. When sex ratio is calculated for children aged six years or less then such a proportion is termed as the child sex ratio (Census of India, 2001).

**Table 1: Sex Ratio in India in 1991, 2001, 2011**

| Year | Overall sex ratio | | | Child sex ratio | | |
|---|---|---|---|---|---|---|
| | Total | Rural | Urban | Total | Rural | Urban |
| 1991 | 927 | 938 | 894 | 945 | 948 | 935 |
| 2001 | 933 | 946 | 900 | 927 | 934 | 906 |
| 2011 | 940 | 947 | 926 | 914 | 919 | 902 |

Source: Census of India, 2011

Table 1 reveals the overall sex ratio as well as the child sex ratio in India. The overall sex ratio has increased from 1991 to 2011 but the child sex ratio has shown a decreasing trend during this time period. Moreover, the sex ratio is higher in rural areas than in urban areas. The overall sex ratio increased from 927 per 1000 males in 1991 to 933 per 1000 males in 2001 and further to 940 per 1000 males in 2011. This increase in sex ratio is attributed to the female education and the participation of women in the societal affairs. But the child sex ratio has declined from 945 per 1000 male children in 1991 to 927 per 1000 male children in 2001 and further to 914 per 1000 male children in 2011. Moreover, the decline in child sex ratio is more than the increase in overall sex ratio. The downward trend in child sex ratio has largely been attributed to sex-selective abortions in some parts of the country (UNICEF, 2011). Access to technological advances of ultra sonography and India's relatively liberal laws on abortion has been misused to eliminate female foetuses (Mishra, 2006) which have reduced the child sex ratio

in India. It has further accelerated the exploitation of the females in the society and has posed a major challenge for social development of the economy.

**Life Expectancy at Birth**

Life Expectancy at birth is the average number of years' a new born child is expected to live under current mortality conditions (Family Welfare Statistics, 2011). It does not represent only the quantitative measurement of health, but it also indicates the adequate standard of living of individuals. India is among the few nations of world where the life expectancy at birth is more for females than males.

**Table 2: Expectation of Life at Birth**

| Year | Males | Females |
|---|---|---|
| 1991-96 | 60.6 | 61.7 |
| 1996-01 | 62.3 | 65.3 |
| 2001-05 | 63.8 | 66.1 |
| 2005-10 | 65.8 | 68.1 |

Source: Family Welfare Statistics, 2011

Table 2 throws a light on the life expectancy at birth for males and females in India. Since 1991, the life expectancy at birth has increased for both males and females but it is higher for females in every time period. In the whole time period from 1991 to 2010, the life expectancy for females increased more than their male counterparts. For males, it increased just 5.2 years, whereas this increase was 6.4 years among females. It is due to the biological advantage that women have a longer life span than the men (United Nations, 2010).

**Fertility Rate by Level of Education of Women:**

Total Fertility Rate indicates the average number of children expected to be born per woman during her entire span of reproductive period (Sample Registration System, 2011). The central factor that affects the fertility levels is literacy of women.

**Table 3: Fertility Rate by Level of Education of Women**

| Education level | Rural | Urban | Total |
|---|---|---|---|
| Illiterate | 3.4 | 3.4 | 3.3 |
| Below primary | 3.2 | 3.2 | 3.0 |
| Primary | 2.5 | 2.7 | 2.5 |
| Middle | 2.2 | 2.3 | 2.2 |
| Class XII | 1.5 | 1.7 | 1.5 |
| Graduate and above | 1.6 | 1.8 | 1.6 |

Source: Sample Registration System, 2011

Table 3 shows the fertility rate by educational level of women in India in 2011. The table reveals that the fertility rate of illiterate females is more than the educated ones in both rural and urban areas. In rural areas, the fertility rate of illiterate women is 3.4, whereas it is just 1.6 for educated women. In urban areas, the illiterate women have 3.4 fertility rate as compared to 1.8 among the women who are graduate or above. Thus, as the women go up the educational ladder, their fertility rate goes on decreasing. It is the united effort of husband and wife together that can contribute to intentional fertility decline and while female schooling may well be responsible for this join effort (Thapan, 1997). The education of women has been a major factor for improving the social condition and thus, contributing the social development of the Indian economy.

**Mortality Rates:**

Another basic component responsible for the population change is mortality. Infant Mortality Rate is defined as the infant deaths (less than one year) per thousand live births (Sample Registration System, 2011). Neo-natal Mortality Rate is the number of infants dying within the first month of life (under 28 days) in a year per 1000 live births in the same year. Post Neo-natal Mortality Rate is the number of infant deaths at 28 days to one year of age per 1000 live births in a given year (Family Welfare Statistics, 2011).

**Table 4: Mortality Rates of Infants**

| Year | Infant Mortality Rate | Neo-Natal Mortality Rate | Post Neo-Natal Mortality |
|---|---|---|---|

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Rate | | |
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 1991 | 80 | 81 | 80 | 55 | 32 | 51 | 31 | 21 | 29 |
| 2001 | 66 | 64 | 68 | 44 | 25 | 40 | - | - | - |
| 2011 | 44 | 43 | 46 | 34 | 17 | 31 | 14 | 12 | 14 |

Source: Health and Family Welfare Statistics, 2011

Table 4 highlights the mortality rates among males and females in India. The infant mortality rates, neo-natal and post neo-natal mortality rates exhibit a declining trend for both males and females. All these mortality rates are low for females than males. For males, the infant mortality rate has decreased from 80 per 1000 live births in 1991 to 44 per 1000 live births in 2011. For females, it has decreased from 81 per 1000 live births in 1991 to 43 per 1000 live births in 2011. The neo-natal mortality rate, has decreased from 55 per 1000 live births in 1991 to 34 per 1000 births in 2011 for males and it declined from 32 per 1000 live births in 1991 to 17 per 1000 live births in 2011 for females. From 1991 to 2011, the post neo-natal mortality rate declined more in case of males as compared to females. A mother's education is linked to better reproductive health and reduction in young children's mortality rates (Gupta and Yesudian, 2006). Education and employment are powerful tools for changing women's position in a direction conducive to lower fertility and mortality rates. Education in general has positive consequences for lowering fertility and child mortality (Thapan, 1997).

**Maternal Mortality Ratio:**

The Maternal Mortality Ratio is the number of women who die as a result of pregnancy and childbirth complications per 100,000 live births in a given year (Family Welfare Statistics, 2011). The maternal mortality ratio in the country has been ‘steadily falling’ during the past decades (Mishra, 2006).

**Table 5: Maternal Mortality Ratio**

| Year | MMR |
|---|---|
| 1997-98 | 398 |
| 1999-01 | 327 |

| | |
|---|---|
| 2001-03 | 301 |
| 2004-06 | 254 |
| 2007-09 | 212 |

Source: Family Welfare Statistics, 2011

Table 5 demonstrates the maternal mortality ratio in India. Though the maternal mortality ratio has declined at a faster pace but still it is significantly high which depicts the vulnerable conditions of Indian women. Haemorrhage and sepsis which are predisposed to a great extent by maternal anaemia, contribute to almost half of the maternal deaths (UNICEF, 2011). In fact, the leading contributor to high MMR in India is lack of access to health care. Anaemia is another factor affecting maternal health and mortality (Saha and Saha, 2010). The table reveals that maternal mortality ratio has declined from 398 per 100000 live births during 1997-98 to 212 per 100000 live births in 2007-09, which is a drastic change in the women's lives. The most important interventions to save maternal lives are access to skilled birth attendants, timely emergency obstetric care, post-natal care for mothers and babies and access to reproductive health services (WHO, 2010).

## Anaemia Status

Anaemia is characterized by a low level of haemoglobin in the blood. Anaemia begins in childhood, worsens during adolescence in girls and gets aggravated during pregnancy (Kalaivani, 2009). Three levels of severity of anaemia are distinguished: mild anaemia (10.0-10.9 grams/decilitre for pregnant women, 10.0-11.9 g/dl for non-pregnant women and 12.0-12.9 g/dl for men), moderate anaemia (7.0-9.9 g/dl for women and 9.0-11.9 g/dl for men), and severe anaemia (less than 7.0 g/dl for women and less than 9.0 g/dl for men) (NFHS, 2009).

**Table 6: Anaemia Status, 2005-06**

| Age | Anaemia Status | | Gender Gap |
|---|---|---|---|
| | Males | Females | |

| | | | |
|---|---|---|---|
| 15-19 | 30.2 | 55.8 | 25.6 |
| 20-29 | 19.3 | 56.1 | 36.8 |
| 30-39 | 23.1 | 54.2 | 31.1 |
| 40-49 | 27.9 | 55.0 | 27.1 |

Source: National Family Health Survey, 2009

Table 6 depicts the prevalence of anaemia among males and females of various age-groups. The prevalence of anaemia is much higher among females than males in every age-group. The age-group of 20-29 reveals the worst condition of women suffering from anaemia where the gender gap is highest at 36.8 per cent. The gender gap is least in the age-group 40-49 which is 27.1 per cent in 2005-06. Iron deficiency is the major cause of anaemia followed by folate deficiency (Kalaivani, 2009).

**Table 7: Level of Anaemia, 2005-06**

| Anaemia | Males | Females |
|---|---|---|
| None | 76 | 45 |
| Mild | 13 | 39 |
| Moderate | 10 | 15 |
| Severe | 1 | 2 |

Source: National Family Health Survey, 2009

Table 7 shows the level of anaemia among men and women. The table indicates that 76 per cent of men have no type of anaemia whereas there are just 45 per cent females who are not suffering from any type of anaemia. Thirty nine per cent of men as against 13 per cent of women are suffering from mild anaemia. In moderate and severe type of anaemia, the gender gap is 5 per cent and 1 per cent respectively. Thus, the anaemia level is high among females than their male counterparts.

**Access to health care among women:**

In India, the access to health facilities among women is socially determined to a larger extent. Their poor health status reveals the lack of access to health related services. They

are incapable to utilize the health facilities available to them due to social and cultural restrictions.

**Table 8: Distribution of Live Births by Type of Medical Attention Received by mother at Delivery (Per cent), 2005 & 2009**

| Type of Medical Attention | 2005 | | | 2009 | | |
|---|---|---|---|---|---|---|
| | Total | Rural areas | Urban areas | Total | Rural areas | Urban areas |
| Institutional deliveries | 34.5 | 24.4 | 70.4 | 57.7 | 48.7 | 87.1 |
| Deliveries attended by qualified personnel | 26.4 | 29.4 | 15.5 | 17.0 | 19.7 | 8.1 |
| Deliveries attended by untrained personnel | 39.2 | 46.3 | 14.0 | 25.1 | 31.4 | 4.7 |

Source: Family Welfare Statistics, 2011

Table 8 shows the access to health care among Indian women through the type of medical attention received by them during their deliveries. The institutional deliveries increased substantially from 34.5 per cent in 2005 to 57.7 per cent in 2009. These increased to 24.3 per cent in rural areas and to 16.7 per cent in urban areas but the percentage was high in urban areas. Providing facilities for institutional deliveries on a mass scale in rural areas is viewed as a long term goal requiring massive health infrastructure investments (Sugathan, et.al, 2001). The deliveries attended by the qualified personnel reduced from 26.4 per cent in 2005 to 17 per cent in 2009. Moreover, it declined in rural as well as in urban areas by 9.7 per cent and 7.4 per cent respectively. The deliveries attended by untrained personnel also reduced by 14.1 per cent during 2005 to 2009. The decline was more in rural areas as compared to urban areas. But still a large proportion of deliveries took place under the supervision of unskilled personnel due to the high costs of qualified personnel.

Thus, it can be easily assessed that the Indian women are still facing tribulations regarding their health. They are not physically fit, mentally alert and socially organised. They lack the basic health facilities which are a matter of concern. They have low nutritional levels which result in high maternal mortality ratios. They are not aware of modern health services

available for their better health. These health hazards of women must be reduced as soon as possible to ensure a well developed society.

## Conclusion and Policy Implications

The roles defined for women are subordinated to those defined for men. In human functioning, the obligations women have are more limiting than those of men. The secondary role of women to men determined by the conventional culture and social outlook has negative impact on their health. Their role in the society is limited to wife and mother only. In India, the women's health reveals a very depressing situation. Most of the indicators of determining health are against the women including the sex ratios, fertility rates and access to health care. Despite the advantage in life expectancy at birth, the Indian women have high maternal mortality rates. Along with this, the progress in the medical sphere has been used in an erroneous manner. The sex selective abortions have reduced the child sex ratio. It is indeed unfortunate that a welfare state, founded on the principles of equality, social justice and democracy should display such inequalities in health and access to health care (Mishra, 2006). Under these circumstances, effective approach towards women's health must be addressed in order to strengthen the entire health system. Education and employment are the tools which serve as the solution to all the health problems of Indian women. Education will improve the health of women by curbing the social and cultural traditions. Along with it, the employment will increase the economic power of women which will in turn help them to take advantage of all health facilities. Improvement in women's health will promote their welfare and will enhance the impoverishment of their families and communities. Without a strong focus on the links between women's empowerment and women's health policy, programs may become like 'grass without roots'.

Whereas, the employment of women is essential to promote gender equality, is also important that the links between health policy, programmes and women empowerment should be established strongly.

For the growth of a plant, there is need to nurture the seed. Similarly, for the growth of a nation, adequate nourishment of women is crucial. Adequate health status of women is essential for the bright future of coming generations. It occupies an important place in the

plans for accomplishment of inclusive growth strategies. But, the depressing health status of Indian women poses great challenges for the future. So, it is indispensable to provide safety nets for the adequate health status of women in India. For this purpose, the following suggestions are being given:

- The conventional approaches regarding the son preference must be curbed. The women become enemy of their own girl foetus under the pressure of their family and the society in the desire of a son. This results in unwanted abortions and poor reproductive health of the women. Promoting gender equality in the social stratification and eliminating the differential treatment among men and women must be augmented to create a fully liberal India. This will in turn give preference to women's health and their access to health care.
- Education and employment must be enhanced among the women. More educational and employment opportunities must be made available to the women. New needs emerge as they enter a new phase of life. Adequate health related information must be provided to women. Education will help the women to take care of their health when they become familiar with the prevailing health facilities. Employment will help them to have access to these health facilities. Thus, the educational and employment programmes must be encouraged among women to ensure their better health.
- Women empowerment is a crucial step to improve the quality of life among women. If the women are empowered, they are induced to fight against discrimination and attain their self-respect. It will enhance women's autonomy and make them capable of taking their own decisions regarding their health care. The investment in health care of women must be raised to empower them and increase their nutritional levels and the access to health care.
- Poverty is still a major hurdle in the women's access to health care. Poverty increases illiteracy and restricts access to health and all welfare schemes. The poor women must be provided with special health packages to ensure their adequate health status. They must be provided not only the health facilities but these facilities must be of superior quality.
- As the women have diverse needs as compared to men, the gender sensitive health facilities must be enhanced to address the health needs of women. To perk up their health status, necessary initiatives must be made at the local and national levels. Public sector

must be strengthened to provide cost free and best quality health facilities to the women. There is a dire need to make the health systems to work for the welfare of women without any discrimination.

- Health insurance is another big step to meet the health requirements of Indian women. The health of women must be insured to prevent the long term illness and threatening ailments. The government must enhance the health insurance of women so that they are capable of bearing the financial burden of their health. It is necessary for women to reduce their dependency on their families. The health insurance during the reproductive periods should be given more importance.
- Regulation of private sector is very significant for the better health status of Indian women. Policies regarding the charges of health services, acceptable levels of health practices etc. must be accomplished for the private sector for equitable distribution of health facilities in India. This sector must be made accountable so that women can have an easy access to private sector health facilities.

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