P: ISSN No. 2231-0045 RNI No. UPBIL/2012/55438 VOL. -5, ISSUE-3, February-2017
E: ISSN No. 2349-9435 Periodic Research

# Problem of Health and Well Being in Indian Women

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**Abstract**

Women in India are experiencing subsequent gender based discrimination attributed to many cultural norms that directly related to multitude of health problems. Health related problems ultimately affect the aggregate economic output of the country. Thus through the present study an attempt has been made to explore the problem of health among Indian women, its causes and consequences. The same study is comparative between health and well – being of rural and urban married women having at least one child. In this sequence, an urban area known as Kanpur city and a rural area known as Ramabai Nagar of Uttar Pradesh, India are selected. 100 rural and 100 urban married women are selected as a sample. Interview schedule is used for data collection having both open and closed ended questions.

The outcomes of the study show that currently women are experiencing different health related problems due to socio – cultural norms associated to the Indian culture. The health problems are more common in rural than urban area and women belong to Lower Economic Group (LEG). Health related problems among women negatively affect to fulfill their responsibilities towards household works, child – care and economic participation.

**Keywords:** Health, Gender –Discrimination, Cultural Norm

**Introduction**

Mere absence of diseases does not denote the complete good health status of a person unless of physical, mental and spiritual well being (WHO, 1978). While considering the social participation of an individual the role of body and mind comes above all because then only a person can perform the defined expected roles assigned to an individual. (Dalal & Mishra, 2006).

Presently health of women in India is a major issue because it affects not only the health of herself only but whole family has to suffer in one way or another. If the mother is unhealthy then most likely she will give birth an unhealthy child (Saha & Saha, 2010). Although the household work performed by a women is not recognized due to no economic gain but undoubtedly her illness affects household economic well – being and ultimately affects the economic growth of a country and if she is working then this magnitude becomes double (Madhiwala & Jesani, 1997). The various types of morbidity which a woman has to face are reproductive problems, pain, injuries, weakness, fever, respiratory problems, problems in the gastrointestinal tract, skin and eye etc (Madhiwala & Jesani, 1997). Discrimination in the upbringing process of a boy and a girl results the poor health problem especially in girls and women in India (Desai, 1994). Boys are more cared since birth in comparison to the girls (IIPS, 1995). If boys get ill then they will be approached to a doctor for treatment while in the matter of girls parents wait till the problem is solved by its own or became serious due to negligence (Bhalla, 1995). Malnutrition is one of the leading factors of poor health of women in India (Chatterjee, 1990). Some Studies showed that only 10% of women were able to get a balanced diet (Khetarpal and Kochar, 2006). Malnutrition causes anemia which is very common among the women of rural and urban areas. More than 50% of women in urban areas are anemic with almost 1/3 suffering moderate to severe anemia (Anil, 2007). According to World Bank (1996), 50 – 60% of all pregnant women in India suffer from anemia. Severe anemia accounts for 20% of all maternal deaths in India (World Bank, 1996). Insufficient availability of nutrients is also responsible for maternal deaths (Jejeebhoy et al, 1995). The Maternal Mortality Ratio (MMR) is declining over the years in India but still it is 57 times that of developed nation like USA (Saha & Saha, 2010). Lack of proper health services causing most of the maternal

deaths (Jejeebhoy & Saumya, 1995). In India due to lack of access to health care contributes to high Maternal Mortality Ratio (World Bank, 1996). Pre natal care of women in rural areas is not good (NFHS – 3). Long distance of health centers prevents the rural population to reach within time to for medical treatment (Bhalla, 1995).

Thus health of Indian women is an important issue to be discussed. All above concerns keeping in mind present study is an attempt to investigate the problems of health among Indian women, its causes and consequences. Common health practices adopted by these women are also explored in this study.

**Methodology**

The study is comparative in nature and compared the health problems of rural and urban Indian women. In this sequence, 100 women from an urban area known as Kanpur city and 100 women from a rural area known as Ramabai Nagar of Uttar Pradesh, India were purposively selected as a sample. All the women selected in the sample were suffering from some health problems and presently have at least one child. Interview schedule was used for data collection having both open and closed ended questions.

**Result**

**Table – 1**
**Socio-Demographic Details of the Respondents**

| Categories | No. of the Respondents | | Total |
|---|---|---|---|
| | Rural | Urban | |
| **Age** | | | |
| 19-34 | 18(18) | 12(12)* | 30(15) |
| 35-50 | 34(34) | 37(37) | 71(35.5) |
| >50 | 48(48) | 51(51) | 99(49.5) |
| **Education** | | | |
| Illiterate | 47(47) | 30(30) | 77(38.5) |
| Primary | 20(20) | 28(28) | 48(24) |
| High-school | 8(18) | 15(15) | 33(16.5) |
| Intermediate | 10(10) | 09(9) | 19(9.5) |
| Graduate | 5(5) | 12(12) | 17(8.5) |
| Post graduate | --- | 06(6) | 6 (3) |
| **Economic Class** | | | |
| Upper Eco. Class | 2(2) | 8(8) | 10(5) |
| Upper Middle eco Class | 6(6) | 10(10) | 16(8) |
| Middle eco. Class | 16(16) | 22(22) | 38(19) |
| Lower Middle eco Class | 27(27) | 25(25) | 52(26) |
| Lower Eco. Class | 49(49) | 35(35) | 84(42) |
| **Types of family** | | | |
| Nuclear | 34(34) | 58(58) | 92(46) |
| Joint | 66(66) | 42(42) | 108(54) |

***Percentage in Parentheses**

Table – 1 shows the socio – demographic details of the respondents. From the Table – 1 it depicts that age of about half of the respondents (48% of the rural and 51% of the urban women) having health problems are more than 50 years, while age of 35.5% of the respondents (34% of the rural and 37% of the urban women) are in between 35 – 50 years. Educational status of the respondent's shows that most of them are either illiterate (47% of the rural and 30% of the urban respondents) or primary educated (20% of the rural and 28% of the urban women). Most of them belong to the families having Lower Economic Class (49% of the rural and 35% of the urban women) or Lower Middle Economic Class (27% of the rural and 25% of the urban women). 66% of the rural and 42% of the urban women is living in the joint families.

**Table – 2 Numbers of Children Given Birth by the Respondents**

| S.N. | No. of the children | No. of the Respondents | | Total |
|---|---|---|---|---|
| | | Rural | Urban | |
| 1 | 1 | 11(11) | 18(18) | 29(14.5) |
| 2 | 2 | 12(12) | 23(23) | 35(17.5) |
| 3 | 3 | 22(22) | 26(26) | 48(24) |
| 4 | 4 | 31(31) | 22(22) | 53(26.5) |
| 5 | >4 | 24(24) | 11(11) | 35(17.5) |

***Percentage in Parentheses**

Numbers of the children given birth by a woman and gap between two births also affect the health of a woman. Data of the present study show that presently 55% of the rural and 33% of the urban women have four or more than four children (Table - 2). Table – 2 also shows that only 11% of the rural and 18% of the urban respondents presently has one child.

**Table – 3 Approximately Gap between Last Two Births**

| S.N. | Gap (in year) | No. of the Respondents | | Total |
|---|---|---|---|---|
| | | Rural | Urban | |
| 1 | 1 | 19(19) | 12(12) | 31(15.5) |
| 2 | 1 – 2 | 35(35) | 24(24) | 59(29.5) |
| 3 | 2 – 3 | 22(22) | 41(41) | 63(31.5) |
| 4 | >3 | 13(13) | 05(5) | 18 (9) |
| 5 | N.A. | 11(11) | 18(18) | 29(14.5) |

***Percentage in Parentheses**

Out of those respondents presently have at least two children (89% of the rural and 82% of the urban), 29.5% of them (35% of the rural and 24% of the urban women) informed that there was approximately one to two years gap between last two births (Table -3). On the other hand 19% of the rural and 12% of the urban respondents reported that they gave next birth within one year (Table – 3).

Anemia is access as most common health problem suffered by a total of 24% (30% of the rural and 18% of the urban women) of the respondents than different respiratory problems like Asthma, T.B. etc. reported by 20% (18% of the rural, 22% of the urban women) of them. 24% of the rural and 12% of the urban respondents inform that they have reproductive health problems like vaginal infections, excessive bleeding, no bleeding, painful bleeding and miscarriage etc. Different bone problems like osteoporosis, arthritis, backache are reported by 12% of the rural respondents in against to 18% of the urban one. Breast Cancer (8% of the rural & 6% of the urban women), Heart diseases (6% of the rural & 10% of the urban women), Depression (2% of the rural &

8% of the urban women) and some others health problems (6% of the urban women) are also reported by the respondents. Respondents were asked to report about the different sources of seeking help after their health problems, then 28% of the rural and 14% of the urban respondents informed that they ignore their health problems and thus do not approach to any health centers yet now (Table – 4). On the other hand 22% of the rural and 15% of the urban respondents are seeking help from untrained practitioners. 18% of the rural and 9% of the urban respondents are depending upon home remedies. Only 22% of the rural and 38% of the urban women approach to the government hospital for seeking help. On the other hand 10% of the rural and 24 % of the urban respondents took help from private practitioners.

**Table – 4**
**Different Sources of Seeking Help**

| S.No. | Different sources | No. of the Respondents | | Total |
|---|---|---|---|---|
| | | Rural | Urban | |
| 1. | Ignore their health problems and do not approach to the health centre | 28(28) | 14(14) | 42(21) |
| 2. | Seeking help from untrained practitioners | 22(22) | 15(15) | 37(18.5) |
| 3. | Depending upon home remedies | 18(18) | 09(9) | 27(13.5) |
| 4. | Approach to the government hospitals | 22(22) | 38(38) | 60(30) |
| 5. | Seeking help from private practitioners | 10(10) | 24(24) | 34(17) |
| 6. | Total | 100(100) | 100(100) | 200(100) |

***Percentage in Parentheses**

Respondents were also asked to inform about the initiative has been undertaken by them at the early stage of their ailment then 86% of the rural and 76% of the urban respondents informed that they ignore their ailment at the early stage. They approach to the medical centers at the later stage of their ailment. They were asked why they ignore their health problems at the early stage, and then about 30.4% of the respondents (30.2% rural, 30.6% urban) informed that they ignore their health problems as they prefer their other family members first during their sickness and approaching them to the health centers. On the other hand 22.1% of the rural and 25% of the urban respondents seek help from the health centers at the later stage as their health problems are ignored by their family members especially by their husbands. They further informed that in most of the times they are not accompanied by their family members to the hospital. Economic dependence (18.6% of the rural and 30.6% of the urban women), carelessness (10.5% of the rural, 15.3% of the urban women) and long distance of the hospitals from their home (11.6% of the rural & 4.2% of the urban) are also access as different causes behind the ignorance of their health problems at the early stage. Living in joint family is also found as constraint in access to the medical centers at the early stage in case of 7% of the rural respondents.

**Table – 5**
**Reasons for Ignorance of Health Problems**

| S.No. | Reasons | No. of the Respondents | | Total |
|---|---|---|---|---|
| | | Rural | Urban | |
| 1. | Preference of other family members first | 26(30.2) | 22(28.9) | 48(29.6) |
| 2. | Their health problems are ignored by their family members | 19(22.1) | 18(23.7) | 37(22.8) |
| 3. | Economic dependence | 16(18.6) | 22(28.9) | 38(23.4) |
| 4. | Carelessness | 09(10.5) | 11(14.5) | 20(12.3) |
| 5. | Long distance of hospital from their home | 10(11.6) | 03(3.9) | 13(8) |
| 6. | Living in the joint family | 06(7) | --- | 06(3.7) |
| 7. | Total | 86(100) | 76(100) | 162(100) |

***Percentage in Parentheses**

From the analysis of data it is found about pre – natal care that only 22% of the rural and 32% of the urban respondents went for routine check-ups and take their medicines regularly during pregnancy. Place of delivery of 24% of the respondents (36% of the rural and 12% of the urban) was not safe as their delivery take place at home.16% of the rural and 8% of the urban respondents informed that their delivery was not attended by trained workers.

From the food – habits of the respondents it is found that, males eat first in their families and they are typically the last to eat with other female members in their family informed by 46% of the rural and 21% of the urban respondents. Only 20% of the rural and 28% of the urban respondents informed that they drink milk daily or eat fruit regularly. On the other hand only 27% of the rural and 35% of the urban respondents reported that they eat properly two times daily and took proper diet in their meal.

**Discussion**

Gender discrimination among the society leads to many poor health problem issues in India (Balarajan et al, 2011). According to World Economic Forum, Gender inequality situation is worst in compared to other countries in India (Raj, 2011). United Nations Development Programme's Human Development report, ranked India 132 out of 187 countries in terms of gender – inequality (United Nation's report, 2011). Patriarchal system of society is mainly responsible for the gender inequality In such

societal system indifferent values, norms, beliefs and behavior are taught to girls since their childhood. Different upbringing parameters for the boys and girls makes the unequal distribution of resources (Das Gupta, 1994). Patriarchal family makes the girls dependent, obedient, powerless and shyness in nature (Jha et al, 2004). In the name of cultural values women are trained to take care of other family members first and at last she should think for herself. Duration of breast feeding, immunization, food – habits, intake of nutritious food items, reporting of illness, rates of admission to the hospitals, access to the health services and to take medical treatment all are concerned with patriarchy, different socialization and gender – inequality in India. Women in India are discriminated in all above aspects and thus suffer more from health problems than men. Sons are considered to be the carriers of the future generation so they get preferences and girls are considered as *paraya dhan* who has to leave the home after marriage are not much cared since birth (Saha & Saha, 2010). Son preferences is also encouraging the dowry system in India (Chatterjee,1990) and resulting the mistreatment of daughter. Malnutrition among women start since birth to death (Chatterjee, 1990). Poor families are not able to feed the last person of the family who is always a woman (Horowitz & Kiswar, 1995).

Villages are not equipped with education and due to many hygiene problems women in rural areas has poor health status. Inadequate medical facilities in rural areas, long distance of health centers from their home and poor resources obtain for treatment from private medical practitioners are some major barriers for availing health care for rural women.

Right to health is a basic human right. On the other hand the result of the present study revealed that women do not access such basic right. Historically discrimination of women on the gender – basis is one of the major causes behind poor health outcomes of them. International Covenant on Economics, Social and Cultural Rights (ICESCR) emphasized the responsibilities of the state to protect the right of all groups and individuals to the enjoyment of the highest attainable standard of physical and mental health. Government of India has been making several efforts in developing health and population policies. There are numerous interrelated problems in regard to the poor health of women (Buckshee, 1997). Thus, there is a greater need to start extensive health care programmes in both rural and urban areas (Rao et al, 2010). Health education also has to play a vital role (Rao et al, 2010). This deep rooted problem needs a larger transformation with greater national and international co-operations (World Bank, 1998).

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