CHAPTER – I

CONCEPTUAL AND THEORETICAL FRAMEWORK

Health is an important aspect for the survival of human. The concepts, knowledge, skills and infrastructure for healthcare have been evolved through the evolution of human civilization in various societies. However, due to gender bias the health priorities for men and women have been different in different traditions and different societies. To understand the problems related to women health this chapter is divided into three Sections: Health status in India, women in India, and concept of health and nutrition and theories of gender.

SECTION- I

HEALTH STATUS IN INDIA:

Health status in India can be understood with its historical perspective, health concerns and health infrastructure in pre- independence and post- independence phases and the analysis of effectiveness of health care systems for the different expected beneficiaries of the society. This section has been organized keeping these aspects in view.

(A) HEALTH SYSTEMS: HISTORICAL PERSPECTIVE:

The historical perspective of public health in India can be studied with the help of the following different phases: India has one of the most ancient civilizations in recorded history which existed thousands of years before the Christian era, known as the Indus valley civilization. Excavations in the Indus valley (e.g. Mohanjodaro and Harappa civilization) showed relics of planned cities with drainage, house and public baths built of bricks suggesting the practices of environmental sanitation, by the ancient people as far back as 3000 BC. India was invaded by the Aryans around 1400 BC. It was probably
during this period, the Ayurveda and Siddha systems of medicine came into existence. Ayurveda as a science of life developed a comprehensive concept of health. The *Manu Samhita* prescribed rules and regulations for personal health, dietetics and hygienic rituals at the time of birth and death, and also emphasized the unity of the physical, mental and spiritual aspects of life. *Sarva Jana Sukhina Bhavantu* (may all men be free from disease and may all be healthy) was an ancient saying of the Indian ages. This concept of happiness has its roots in the ancient Indian philosophy of life, which conceived the oneness and unity of all people, wherever they lived. The post Vedic period (600 BC-600 AD) was dominated by the religious teaching of Buddhism and Jainism. Medical education was introduced in the ancient universities of Takshila and Nalanda, leading to the title of Pranacharya. Hospital system and its infrastructure were developed during the period of Rahula (Son of Buddha) for men, women, animals and this system was continued and expanded by King Ashoka. The next phase in Indian history (650 AD-1850 AD) witnessed the rise and fall of the Mughal empire. The Muslim rulers intruded into India around 1000 AD. The Arabic system of medicine, popularly known as the Unani system, the origin of which can be traced to Greek medicine became a part of Indian medicine with changes in the political scenario in India. The torch which was lighted thousand of years ago by the ancient sages grew dim, medical education and medical services become static and the ancient universities and hospitals disappeared (Park; 1995).

(B) HEALTH STATUS: PRE-INDEPENDENCE:

The period of British rule have evidences about causes of deaths which has been inferred from small surveys or from special enumerations during epidemics, of plague or cholera. To estimate population as well as mortality and fertility levels prior to 1871, sketchy information are available which may be interpreted in different ways (Morris: 1974). Das Gupta and his colleagues (1972) argued that the growth in population was largely during the relatively stable years of Mughal power between 1600 AD and 1675 AD, with little growth from 1675 AD to 1800 AD when Mughal regime declined under the internal strains and external pressures. However, estimates of mortality and fertility between 1800 and 1870 have to be based on data derived from the Censuses after 1871 and more substantial materials from 1851. The life expectancy figures are heavily
dependent on demographic models which may be unrealistic as ages were wrongly recorded or people in some age groups were under recorded. As Alice Clark (1985) has demonstrated, newer techniques less vulnerable to these problems would produce much lower estimates of life expectancy at birth, especially for females, and correspondingly higher death rates (Tinker: 1977).

Generally it is considered that from 1800 to 1921 India had high birth rates (fluctuating to a small extent, but over 40 per 1,000 populations in most years). The peaks in mortality are particularly associated with droughts and famines; in ‘normal years, mortality was affected more by endemic diseases and poor living standards. Famines were often followed by epidemics whose effects were magnified by malnutrition in the vulnerable groups during the preceding years. Mitra (1978) has listed incidences of droughts and famines reported between 1729 and 1973. They rarely affected the entire country. From the 1830s onwards, when reporting improved, a famine, scarcity, or draught was reported from somewhere in the country every three years or so. Bhatia (1967) argued that there was a much higher frequency of famines in the nineteenth century than in the preceding period, especially in Bengal, with the worst occurring during the fifty years after 1860. Widespread and severe famines and droughts occurred in 1877 and 1878 as well as in 1891 and 1898 (accompanied by an epidemic of plague); and in 1919 and 1920 (preceded by the influenza epidemic), (Davis: 1951).

Before independence, the situation was very critical, the death rate was very high (29.2 per 1000 of population in 1931). About 5.75 per cent of deaths out of total deaths in 1940s were due to cholera, small pox and plague. The life expectancy for male (32.09 years) as well as for female (31.37 years) was very low in 1941 (Government of India: 1947). All this happened due to lack of basic and preventive medical facilities. So in order to improve the health status of people, the Indian government adopted modern system of medicine after independence. The government appointed a committee under the chairmanship of Sir Joseph Bhore, which is known as Bhore Committee (1943). This committee was appointed by the government of India to review the existing health situation from time to time and to recommend measures for further actions. Brief review of the recommendation of the committee, which is an important landmark in the history of public health, is given below:
(a) Integration of preventive and curative services at all administrative levels.

(b) The committee visualized the development of primary health centers.

(c) Major changes in medical education which includes 3 months’ training in preventive and social medicine to prepare ‘social physicians’ (Government of India: 1946).

(C) HEALTH STATUS: POST INDEPENDENCE:

Several committees were set up by Indian Government Post independence to take care of the needs for further development and expansion of health services in the country.

Committees set up by Indian Government are as follows:

1. Mudaliar Committee was appointed in by the Government of India 1962 which was knows as “Health Survey and Planning Committee to make recommendations for further development and expansion of health services. The Committee found that quality of services provided by the primary health centers is inadequate and advised strengthening of the sub-divisional and district hospitals so that they may effectively function as referral centers (Government of India: 1962).

2. After that Chadha Committee was appointed by the Government of India (1963) under the chairmanship of Dr. M.S. Chadha to study necessary arrangements for the maintenance phase of the National Malaria Eradication programme. The Committee recommended that vigilance through medical institutions must be developed to the fullest extent. All medical institutions, Government or Non-Government private medical practitioners, irrespective of the system of medicine they practise, and all professional and other workers should be harnessed. The members of panchayats, block development committee, Mahila mandals, youth clubs, other voluntary agencies, teachers, etc. should participate and efforts should be so made that every village, hamlet or locally has one “voluntary collaborator.” All efforts should be made to establish primary health centers provided for in the current plan period particularly for in the areas entering the maintenance phase. The States that have a plan programme for establishing a certain number of midwifery or maternity and child health centers every year should give priority to
their establishment in the areas deficient in adequate medical coverage. In urban areas, institutional case detection should be the mainstay. The major medical institutions with heavy out-patient attendance should have a person specially detailed to take clinical samples including blood smears. These institutions should have a separate clinical side-room (Directorate General of Health Services: 1963).

3. Jungawalla Committee on Integration (1967) looked into various problems related to integration of health services, abortion of private practice by doctors in government services, and the service conditions of doctors. This Committee recommended integration of all levels of health organizations in the country (Government of India: 1967).

4. Multiple activities of the mass programmers like family planning, smallpox, leprosy, trachoma, etc. were making it difficult for the states to undertake them effectively because of paucity of funds. This matter came for discussion at a meeting of the Central Council of Health held in Bangalore in 1966. The Council recommended that those related questions may be examined by a Committee of health secretaries under the Chairmanship of the Union Health Secretary, Shri B. Mukerji (1968). The Committee worked out details of the basic health services which should be provided at the block level (Government of India: 1968).

5. Kartar Singh Committee (1973) was constituted to form a framework for integration of health and medical services at peripheral and supervisory levels. It recommended that various categories of peripheral workers should be amalgamated into a single cadre of multipurpose workers (male female). The works of 3-4 male female multipurpose workers was to be supervised by one health supervisor. One primary health centre should cover a population of 50,000. It should be divided into 16-sub-centre (one for 3000-3500 population) each to be staffed by a male and a female health worker (Jungawalla Committee on Integration (1967) looked into various problems related to integration of health services, abortion of private practice by doctors in government services, and the service conditions of doctors. This Committee recommended integration of all level of health organizations in the country (Government of India: 1973).
6. Srivastava Committee was set up in 1974 as “Group on Medical Education and Supports Manpower” to determine the steps needed as well as to identify the priorities, and develop a curriculum for health assistants, who were to function as a link between medical officers and multipurpose health workers and who were supposed to provide health care, family welfare and nutritional services. It recommended that a cadre of semi-professionals at village level health workers should be developed within the community. Steps should be taken to develop a referral system from Primary Health Centers (PHCs) to hospitals at tehsil, district and regional levels and the medical colleges. A medical and health education commission on the lines of University Grant Commission should be established (Government of India: 1975). Acceptance of the recommendations of Srivastava Committee in 1977 led to the launching of the Rural Health Scheme.

(D) HEALTH CARE AND FIVE YEAR PLANS:

In five year plans, the Indian Government gave more emphasis to improve health infrastructure which is discussed below:

First Five Year Plan

In early 1950s the government of India adopted some of the recommendations of the Bhore Committee which were in the form of setting up of Primary Health Centers (PHCs), for providing integrated health services as a part of Community Development Programme. During the first Five Year Plan, family planning Programme was introduced by the Government. The main objective of this plan was to improve the quality of health through a variety of training programmers. At the end of this plan, there were 12,600 hospitals and dispensaries throughout the country. But these facilities were not satisfactory. So the Government setup Mudaliar Committee to review the infrastructure and functioning of the medical institutions. This committee emphasized the consolidation and integration of health infrastructure (Government of India: 1952).
**Second Five Year Plan**

The main objective of this plan was to improve the health infrastructure i.e. dispensaries, health care staff (doctors, nurses), hospitals etc. throughout the country (Government of India: 1956).

**Third Five Year Plan**

The Third Plan was marked by a very high priority to the family planning programmes and to control the communicable health diseases. The main objectives of this plan were to extend health services to bring out progressive improvements in the health of the people by ensuring a certain minimum of physical well-being and to create conditions favorable to greater efficiency and productivity of the workforce. The main stress was laid on preventive health services. A number of efforts was made to eradicate malaria, smallpox and to control communicable disease. It was also decided to integrate the Mother and Child Health Programme with family planning (Government of India: 1961).

**Fourth Five Year Plan**

In Fourth Plan, targets for Maternal and Child Health (MCH) were also set as recommended by MCH advisory committee. In maternal health services, targets were set for immunization of pregnant mothers against tetanus and also for the prophylaxis Programme against nutritional anemia (Government of India: 1969).

**Fifth Five Year Plan**

During Fifth Five Year Plan, minimum needs programmes were launched in order to remove poverty. The package provided elements of health, family, nutritional environmental, improvement and water supply apart from elementary adult education, roads electrification and rural areas and housing for the landless labours in keeping with the people oriented strategies of health for all by A.D. 2000. The community Health Volunteers (CHV) joined the PHC network to make service more meaningful for the community and Dai Training Programme was initiated and was supposed to help the MCH work (Government of India: 1974).
Sixth Five Year Plan

Sixth Five Year Plan also proposed that health be viewed as a part of the human development strategy. This plan extended the emphasis on infrastructural development and integration of services at the PHC level and to improve health and nutritional status through the various extension programmes for immunization, prophylaxis or supplementary nutrition (Government of India: 1980).

Seventh Five Year Plan

Seventh Five Year Plan emphasized priorities for women's health care. Education on communicable diseases, control and containment of newly emerging health problems like cancer, coronary heart diseases, hypertension, and diabetes were the other areas considered in the Seventh Five Year Plan (Government of India: 1985).

Eighth Five Year Plan

In the Eight Five Year Plan in health related aspects more emphasized was given to AIDS Control, which had emerged as a new public health problem in the country (Government of India, 1992).

Ninth Five Year Plan

In the Ninth Five Year Plan, the major objective was to control the rapid growth of population. The other objectives of the plan were to provide pure water, primary health care and nutrition to the weaker section of the society. Reproductive and child programmes were given special attention. These programmes also get some external funding, mainly from World Bank. Like some other plans, the government offered organized, logistical, financial and technical support to voluntary agencies active in the field of health (Government of India: 1997).

Tenth Five Year Plan

During the Tenth Five Year Plan efforts were made to improve preventive, curative and rehabilitative services for non-communicable diseases throughout the country at all levels of health care (Primary, Secondary and Territory). The national programme for control of Blindness, National Cancer Control Programme, National Mental Health Programme, Iodine Deficiency Disorder (IDD), related control
programmers are to be implemented. Further, a new scheme for providing medical assistance in the ‘golden hour’ to the accident victims to reduce death due to trauma has been introduced (Government of India: 2002).

**Eleventh Five Year Plan**

The main objectives of the Eleventh Five Year Plan in relation to improve the health services in the country were to review the goals, objectives, strategies and expected outcomes of the National Rural Health Mission (NRHM) in the end of eleventh Five Year period at all levels, to review the implementation of major health and family welfare programmes and suggest measures for rationalizing the infrastructure strategies for improving efficiency and for the delivery of services with a special focus on women and children (Government of India: 2007).

**Twelfth Five year Plan**

In the Twelfth Five year Plan, that starts next year (2012), the planning Commission has decided to increase its spending on health to 2.5 per cent of the GDP (Sinha Kaunteya; 20th Nov. 2011, Times of India) from 1.2 percent in 2009 which is among the lowest in the world. The Indian government has intended to increase public spending on health from 1.2 per cent of GDP to 3 per cent by the end of 2022. The consequence of low public spending on health is leading to high private out-of-pocket expenditures.

**(E) HEALTH FACILITIES AND HEALTH MANPOWER:**

Health manpower planning is an important aspect of community health planning. It is based on a series of accepted ratios such as doctor-population ratio, nurse-population ratio, bed-population ratio, etc. The norms suggested by the Mudaliar Committee (1961) have been the basis of health manpower planning in India. The country was producing annually, on an average, 12,000 allopathic doctors, 3,500 Ayurvedic graduates, 600 Unani graduates, 70 Siddha graduates and 9,000 homeopathic graduates.

There are nearly 2.9 lakhs of allopathic doctors registered with the medical council of India and over 3.8 lakh doctors trained in traditional systems of medicine including Homeopathy, Ayurveda, Unani and Siddha; nearly 1.6 lakh nurses, 5.1 lakh trained dais
and 3.7 lakh village Health Guides. Their numbers are on the increase. In 1983, the national average of doctor-population ratio was 1:2610; population bed ratio was 1:1447; and nurse-population ratio was 1:2251. Although the averages are satisfactory on a national basis, they vary widely within the country. For example, in the case of doctors, there is one doctor per 11,000 to 13,000 populations in Andhra Pradesh, Assam and Rajasthan, whereas there is one doctor per 1252 population in Pondcherry, one per 1712 in Karnataka, and one per 1362 in Haryana. There is also misdistribution of health manpower between rural and urban areas. Studies in India have shown that there is concentration of doctors (up to 80 per cent) in urban areas where only 20 per cent of population live (WHO: 1981).

There were nearly 7,369 hospitals; 21,874 dispensaries, 11,000 primary health centers 83,008 sub-centers with a total bed capacity of 5.1 lakhs and 106 medical colleges with an intake of 12,000 to 13,000 per year till 1981 (Census: 1981). However, the infrastructure has increased significantly since then.

There are at present 1, 46,026 Sub-Health Centers (SHCs), 23,236 Primary Health Centers (PHCs) and 3,346 Community Health Centers (CHCs) in India. To meet 2001 population norm, additional 19,269 SHCs, 4,337 PHC and 3,206 CHCs are needed. While 60,762 SHCs, 2,948 PHCs and 205 CHCs need buildings, several others having buildings need toilet, electricity and drinking water facilities, equipment and medicines and adequate resources for asset management and maintenance. Rural health centers are served by 28,930 nurse midwives, 1, 33,194 additional nurse midwives, 61,907 male medical professional workers, 17,708 pharmacists and 58,752 paramedical staff, in addition to non-technical staff. While 9869 PHCs were with single doctor and 5769 SHCs are without additional nurse midwives, most of them face very high rate of staff absenteeism.

At the end of 2000, India alone accounted for nearly one-fourth (364 million) of the world’s poor, highest number of maternal deaths and undernourished children and one-third of the world’s under-weight children (Patil: 2002).

There are 8 lakh hospital beds and 10 lakh qualified medical practitioner which counts to 85 beds and 110 doctors per lakh population (Census: 2011). If distributed
rationally this is a fairly adequate number, but the reality is different and far away from the adequacy especially with sociological concerns. First, 80 per cent of the qualified practitioners are in the private sector and they work without any regulations or control whatsoever, and of course, for profit. The private health sector market is completely supply induced and the patients are treated various medical systems e.g. Ayurveda, Homeopathy, Unani, Siddha, etc. as well as with modern allopathy. Thirdly, two –third of private practitioners are located in urban areas when 70 per cent of the population resides in rural areas. Fourthly, the public health sector too has an urban bias. As much as 80 per cent of public sector medical care services and consequently as much of the budget for medical cares are limited to urban areas and due to this unequal distribution of health facilities and health related manpower the rural areas are highly deprived of the adequate health services. The rural areas have primary health centers (PHCs) which provide mostly preventive and primitive services like immunization, ante-natal services and family planning services, but medical care which is the people’s main demand are largely located in the urban vicinities. Apart from the formal health sector discussed above, there is the informal sector of hereditary, caste-based and unqualified practitioners of various kinds. Their number, though not known, is as large as or perhaps larger than the formal sector. Various types of unqualified practitioners are ranging from downright quacks to paramedics, dais, witchcraft, herbalists, and a variety of others and of course the local disease technique specialists like abortionists, jaundice specialists, snakebite specialists, etc.

**TABLE 1.1**

<table>
<thead>
<tr>
<th>Health System</th>
<th>Number</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hospital beds</td>
<td>633545</td>
<td>2002</td>
</tr>
<tr>
<td>Hospital beds per 10,000 population</td>
<td>9</td>
<td>2006</td>
</tr>
<tr>
<td>Number of health sub centers</td>
<td>137371</td>
<td>2006</td>
</tr>
<tr>
<td>Primary health Centers</td>
<td>22842</td>
<td>2001</td>
</tr>
<tr>
<td>Community Health centers</td>
<td>3043</td>
<td>2001</td>
</tr>
<tr>
<td>Physicians per 10,000 population</td>
<td>7</td>
<td>2005</td>
</tr>
<tr>
<td>Nurses per 10,000 population</td>
<td>7.85</td>
<td>2004</td>
</tr>
</tbody>
</table>

When we look into the data available in public domain or health system and human resource in India during the recent years, the resources are too meagre in relation to the ever increasing population (Table 1.1). According to WHO and Word Bank Reports (2006) only 9 beds were available for 10,000 populations, whereas only 7 physician and 7.85 nurses were available for this population (WHO: 2005).

Health and education of all human beings are precious assets of the nation. It is nation’s moral, legal and constitutional responsibility to promote, restore or maintain the health status of its population through meticulously designed policy, plans and programs; effectively implementing, monitoring and evaluating them to yield targeted results in respect of health care infrastructure, manpower support, and provision of clean drinking water, sanitation and hygiene, besides a host of other interrelated activities. In this background an attempt has been made here to underline the present status of health service infrastructure, its impact with sharp focus on UN Millennium Development Goals and need to integrate health service infrastructure with the Self – Help- Groups promoted, nurtured and linked with rural financial institutions to empower poor rural women socially, economically and politically and lift them above poverty line.

(F) HEALTH INDICATORS IN NDIA:

TABLE- 1.2

HEALTH INDICATORS IN INDIA 2011

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>India (per thousand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude Birth Rate</td>
<td>20.97 birth/10,000 population</td>
</tr>
<tr>
<td>Crude Death Rate</td>
<td>7.48</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>2.62 Children born/women</td>
</tr>
<tr>
<td>Maternal mortality Rate</td>
<td>212</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>53</td>
</tr>
<tr>
<td>Child Mortality Rate</td>
<td>2.54</td>
</tr>
<tr>
<td>Life Expectancy at Birth</td>
<td>66.71 Years</td>
</tr>
</tbody>
</table>

Source-Economic Survey: 2011
Health indicators in India in year 2011, shows crude birth rate at 20.97 per thousand, crude death rate 7.48 per thousand, total fertility rate 2.62 per thousand, maternal mortality rate 212 per thousand, infant mortality rate 53 per thousand and child materiality rate 2.54 per thousand (Economic Survey: 2011).

Millennium Development Goals:

In September 2000, 189 Member States of the United Nations adopted the UN Millennium Declaration, incorporating eight Millennium Development Goals (MDGs) of which three sharply focused on “health” viz.

a) Reduce child mortality (Target: Reduce by two-thirds the mortality rate among children under five).

b) Improve maternal health (Target: Reduce by three quarters the maternal mortality ratio).

c) Combat HIV/AIDS and the incidence of malaria and other major disease) (United Nation Secretary General: 2000).

The level of maternal mortality varies greatly from state to state, with Gujarat having the lowest ratio (135) and two states (Rajasthan and Uttar Pradesh) having ratios over 677 and 600 (WHO: 1996). This differential maternal mortality is most likely determined by the differences in the socio-economic conditions of women and accessibility levels to health care services among different states of the Indian Republic.

SUMMARY:

The human society initially acquired knowledge through its experiences and even during the ancient civilizations India had planned cities like Mohanjodaro and Harappa with sanitation facilities and good health concerns. Though the recorded history is fragmented and does not convey a complete scenario of the ancient health systems, it seems that the, Ayurveda and Siddha systems of medicines were adopted after Ryans entered into India, as early as around 1400 BC. The documented evidences suggest that in post Vedic period when Buddhism and Jainism emerged, some institutionalization and rationalization of health system were established. With improvement of Muslim rulers in India the Unani system was established. The Britishers had more modern system of
medicine. Which they brought with them in India, but due to their colonial approach and expenditure involved in this important system, it could not reach the large Indian population.

The British period had recorded higher mortality rates and restated epidemic diseases like plague, cholera malaria, smallpox, tuberculosis etc. The major focus of early 20th century was struggle for independence and after independence when India become a state fully ruled by Indians, health and education were takes as priority concerns in post-independence ara. Initially, some committees were constituted consisting of learned intellectuals from various related sectors and priorities were drawn in health sector which was included in various five year plans various five year plans in relation to health concerns, health facilities and health manpower. We can see the intention of the Governments to develop a countrywide infrastructure in initial phase and later after realizing a disparity in urban and rural health facilities to expand the a government sponsored infrastructure and manpower towards rural India.

In addition, the Government Infrastructure for health care is expected to meet the new requirements of presently lesser known diseases like cancer, diabetes, heart diseases, HIV, hepatitis etc, bird flue, encephalitis etc. A focus was also made on child mortality which was a major indicator for socio-economic growth of the country; and with these efforts many specific health concerns related to women and specially women in rural India and that too in vulnerable and underprivileged socio-economical groups were realized. In some recent five year plans the health concerns have been focused to women and child health and various objectives, plans and programs have been included in these plans. The rural India is not a homogenous structure. It has much social economical, cultural and geographical variability. The women are more vulnerable groups within the rural areas and within the various regions in same political state of the country.

The health care of women is an emerging area of sociological studies which needs investigations and analysis of available health facilities, health man power health concerns, health related programs. The operations and actual execution of programme in fields at micro level is to draw a picture of the present health related problems of rural women in terms their caste, class and religion, size of family, education of the family,
culture of the area in which they are residing. It is very essential to understand the impact of various social, economical, cultural factors which are varied in terms of regional differences. This study is an effort to understand the health concerns, health infrastructure, health manpower and effectiveness of health programs for the women of different groups of women in a rural population of remote, backward district of eastern Uttar Pradesh, named Deoria which is located near Bihar and Nepal.

SECTION II

WOMEN IN INDIA:

Women, the word sounds so powerful. Since eternity, women have played a role more important than men and that is no exaggeration. The world would not have been the same lovely adorable and livable place without wonderful contribution so selflessly made by women. It has been said that, you teach a female and you build up a nation and truth can’t be closer than that. Women have always carried the burden of being a wife, mother, sister all on their own and we need not to explain how magnificently they have carried this position.

Men and women complement each other. If men were supposed to handle outside stuff then women were more responsible for internal affairs. The only difference in this notion is, today women are equally competent behind the veils and outside world. They are more confident and one can find them in every possible sphere of human’s life. No male bastion is untouched by females and that’s a wonderful sign of strides made by women. Urban women in India always had more advantages and opportunities than women residing in rural places. Better education, better economic resources, and more availability of required things for urban women and yet rural women have made rapid improvements despite lacking in basic facilities. We have yet to attain the state of complete women empowerment but signs of gradual improvement are definitely there. India in last few decades has remained more of a male-dominated society.

Women used to command acute power and importance in our ancient culture. The proof of this fact can be found in all the scriptures and even our mythological stories. We worship Goddess Durga, Lakshmi, Saraswati and many others. That shows how Indian civilization had revered the female. However, things have not remained the same in the
recent past. The social fabric has acquired completely new dimensions. The women are considered less powerful and important than men, yet situation is not entirely bleak. Thanks to the efforts of government, NGOs, social welfare organizations and many such institutions, there has been a drastic improvement. Many private corporate bodies have also taken a keen interest in improving the economic status of women and the results are extremely encouraging. Pandit Jawaharlal Nehru had once said, “You can tell the condition of a nation by looking at the status of its women”. How true! We completely subscribe to this belief and steps are on its way to further improve the condition of rural women in India.

However much a mother may love her children, it is all but impossible for her to provide high-quality child care, if she herself is poor and oppressed, illiterate uninformed, anaemic and unhealthy, and has five or six other children, lives in a slum or shanty, has neither clean water nor safe sanitation, and is without the necessary support either from health services, or from her society, or from the father of her children.

- Vulimiri Ramalingaswami, “The Asian Enigma”

The persistence of hunger and abject poverty in India and other parts of the world is due in large measure to the subjugation, marginalization and disempowerment of women. Women suffer from hunger and poverty in greater numbers and to a great degree than men. At the same time, it is women who bear the primary responsibility for actions needed to end hunger and improve education, nutrition, health and family income. The Indian constitution grants women equal rights with men, but strong patriarchal traditions persist, with women’s lives shaped by customs that are centuries old. In most Indian families, a daughter is viewed as a liability, and she is conditioned to believe that she is inferior and subordinate to men. Sons are idolized and celebrated. May you be the mother of a hundred sons is a common Hindu wedding blessing. The origin of the Indian idea of appropriate female behavior can be traced to the rules laid down by Manu in 200 B.C.: “by a young girl, by a young woman, or even by an aged one, nothing must be done independently, even in her own house”. “In childhood a female must be subject to her father, in youth to her husband, when her lord is dead to her sons; a woman must never be independent”. 

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(A) WOMEN AND DISCRIMINATION:

Looking through the lens of hunger and poverty, there are seven major areas of discrimination against women in India:

- **Malnutrition:** India has exceptionally high rates of child malnutrition, because in India women eat last and least throughout their lives, even when pregnant and lactating. Malnourished women give birth to malnourished children and this way cycle perpetuates.

- **Poor Health:** Females receive less health care than males. Many women die during childbirth. Working conditions and environmental pollution further impair women’s health.

- **Lack of Education:** Families are far less likely to educate girls than boys, and far more likely to pull them out of school, either to help out at home or from fear of violence.

- **Overwork:** Women work longer hours and their work is more arduous than men’s, yet their work is unrecognized. Men report that “women, like children, eat and do nothing.” Technological progress in agriculture has had a negative impact on women.

- **Unskilled:** Women’s primary employment is in agriculture which is an unskilled job.

- **Mistreatment:** In recent years, there has been an alarming rise in atrocities against women in India, in terms of rapes, assaults and dowry-related murders. Fear of violence suppresses the aspirations of all women. Female infanticide and sex-selective abortions are additional forms of violence that reflect the devaluing of females in Indian society.

- **Powerlessness:** While women are guaranteed equality under the constitution, legal protection has little effect in the face of prevailing patriarchal traditions. Women lack power to decide to whom they will marry, and are often married off as children. Legal loopholes are used to deny women inheritance rights.
India has a long history of activism for women’s welfare and rights, which has increasingly focused on women’s economic rights. A range of government programs have been launched to increase economic opportunity for women, although there appear to be no existing programme to address the cultural and traditional discrimination against women that leads to her abject conditions.

(B) WOMEN AND HEALTH SECTOR:

With the dismal picture of health care in India, not much can be expected in favor of women as user of the health system. The health care attention of both the private and public health system towards women is to view them as mothers. While the private nursing home sector mostly comprises maternity homes, the public health sector’s major concern vis-vis woman is to prevent them from becoming mothers. The private maternity homes cater to the urban population and the middle classes (about 5000 lakh women in the reproductive ages) the public sector’s health services offer family planning services in both urban and rural areas covering over 10 crore couples. The maternity service available under public sector, especially in rural areas mostly through service available under public sector, especially in rural areas mostly through paramedics like auxiliary nurse midwives (ANMs) and trained dais (Mukhopadhyay: 1998).

Beyond the above and some other occasional service like antenatal care and abortion service (both within the context of family planning), little else is available to women to address their general and other gender-specific health care needs. Of course, the informal sector practitioners do cater to some specific needs of women like abortion, white discharge, psychical problem etc., but very little of it is documented to enable a discussion or make comments. Women in India, and especially those in rural areas, could not voiced their concern over their reproductive, sexual and gynecological health needs. Even something as obvious as menstruation is grossly neglected and this has serious consequences because many diseases in our country relate to blood loss, tuberculosis, malaria, kala azar, hookworm and hence makes anaemia an extremely important concern of women’s health which currently receives little attention (Mukhopadhyay: 1998).

The sociology of health is emerging as a more substantial area of research in sociology. Today it has advantage of preventive measures in health care and planning for
health care and the awareness on the nutritional status, consumption habits and the balance diet in the society for better health management. Optimal nutrition using economical food purchasing can be prescribed by such efforts which can help to maintain an adequate health to all especially to our women and children who have been suffering with malnutrition more conspicuously (Mandal, 2003; Roy: 2004).

(C) HEALTH OF INDIAN RURAL WOMEN:

India, with a population of 1,21,01,93,422 is the world’s second most populous country out of which female population is 58,64,69,174 and that of male is 62,37,24, 248 (Census of India: 2011). India has 16 percent of the world’s population, but only has 2.4 percent of its land, resulting in great pressures on its natural resources. Over 70 percent of India’s population currently derives their livelihood from land resources, which includes 84 per cent of the economically active women. India is one of the few countries where males significantly outnumber females, and this imbalance has increased over time. India’s maternal mortality rates in rural areas are among the world’s highest. From a global perspective, Indian accounts for 19 percent of all live births and 27 percent of all maternal deaths (Dasgupta: 2006). There seems to be a consensus that higher female mortality between ages one and five and high maternal mortality rates result in a deficit of females in the population. Chatterjee (1990) estimates that deaths of young girls in India exceed those of young boys by over 300,000 each year and every sixth infant death is specifically due to gender discrimination. Of the 15 million baby girls born in India each year, nearly 25 percent will not live to see their 15th birthday.

“Although India was the first country to announce an official family planning programme in 1952, its population grew from 361 million in 1951 to 844 million on 1991. India’s total fertility rate of 3.8 births per woman can be considered moderate by world standards, but the sheer magnitude of population increase has resulted in such a feeling of urgency that containment of population growth is listed as one of the six most important objectives in the Eighth Five-Year Plan (Dasgupta: 2006).

Since 1970, the use of modern contraceptive methods has risen from 10 percent to 40 percent, with great variance between northern and southern India. The most striking aspect of contraceptive use in India is the predominance of sterilization, which accounts
for more than 85 percent of total modern contraception use, with female sterilization accounting for 90 percent of all sterilizations.

The most common problems with the women are lack of basic amenities such as food, water, fuel, fodder and health facilities. In addition, the deterioration of the natural environment and the fact that many of their traditional occupations were no longer viable were conditions that were making it increasingly hard for women to continue sustaining their families, as they had done in the past. *Swayam Shiksham Prayog* SSP is a loose, informal network of women’s collectives, voluntary organizations, action groups and unions (Chambers: 1983).

Rural women’s health is compromised as a result of a web of interrelated factors operating at different levels. One can attribute the cause of death of a rural woman to hemorrhage during childbirth, but this does not get at the myriad of indirect factors that also led to her death. Poverty among rural Indian populations has a devastating impact on rural women’s health. Many pregnant rural woman cannot afford the costs associated with facility based care, travel to reach a facility or the lost income of those accompanying the woman, and so do not receive adequate care. Poverty can cause delays in seeking appropriate health services until a condition reaches its most critical stage (Singh: 2005). Poverty also plays a role in rural women being forced to partake in activities that increase their exposure to HIV and other AIDS (Shah: 2005). Literacy and education also play a role in rural women’s reduced health status (Johnston: 2003).

Geography is another factor that impedes rural women’s access to health services. Rural women in India affected by the Tsunami also reported similar trials; no visits by gynecologists, no sanitary pads or underwear, and no care at government hospitals for lactating women who had lost their babies and were suffering with milk clotted breasts (Bunad: 2006). Conflicts and natural disasters dramatically alter the status of rural women’s health, as what little health infrastructure previously in place is quickly dismantled.

Culture and society play a significant role in rural women’s health status and access to services. Socio-cultural norms shape beliefs and attitudes and condition human behaviors in ways that can be damaging to one’s own or another person’s health and
well-being. Long standing and entrenched gender inequalities impact rural women’s health in Asia. Rural communities adhere more rigorously to customary laws and norms of social stratification that perpetuate biases against rural women—biases which impact the allocation of assets, power, rights, status, and opportunities (Rao: 1998). Rural women have less access to basic resources (e.g. social, health, educational, and agricultural service systems) compared to their male counterparts. Moreover, biases result in rural women being treated with contempt, humiliated, violated, and discriminated against, which leads to their lowered self-esteem and feelings of fear and loneliness. The systematic bias against females is revealed most starkly in the sex ratios between males and females in India as male preference leads some women to terminate their pregnancies if they know or suspect they are carrying a female.

The violence that many rural women face at the hands of their husbands and other family members is one of the most physically and psychologically damaging experiences faced by them. The degree of acceptance of such behaviors in many rural communities, combined with the women’s powerlessness to stop such actions, including the lack of someone to turn to for help, all compound to keep rural women in abusive relationships and limit positive behavior changes on the part of men. Stressful circumstances appear to intensify the abuse of rural women. In India, after the 2004 Tsunami, it was reported that wife battering was rampant in the camps (Burnad: 2006).

Women’s lack of decision-making power is apparent in their inability to control when and to whom they will be married. Early marriage is more common in rural areas and unfortunately, this can negatively impact their health and well-being (CARAM, Asia: 2006). Pregnancy often follows soon after marriage, which carries a higher risk of complications for adolescents as their reproductive systems are not fully developed. Women who marry at a young age, who often drop out of school, also have less of an opportunity to learn about their sexual and reproductive health and rights and how to access related services. With minimal education and limited access to reproductive health services, they are left on their own to manage their fertility and sexual and reproductive health and well-being (Solomon, S. et al: 1998).
Socio-cultural norms also influence health seeking behaviors and health delivery, for example, male village-level health providers in India report that taboos prohibit them from conducting physical examinations or invasive diagnostic and therapeutic procedures on rural women, a situation that results in their providing care that is ineffective and more expensive (e.g. pills and shots) and can delay correct diagnosis and access to appropriate facility–based care (Johnston: et al: 2003).

Real equity in women’s health must recognize and put in place mechanisms to overcome barriers, such as poverty and illiteracy that negatively impact rural women’s health and ultimately work towards changing such conditions. This should also include the removal of laws and policies that are harmful to rural women’s health. Health programmers when they do reach rural areas are rarely comprehensive and fail to consider contraception, violence against women, abortion, and accurate and adequate health information.

Resources remain a persistent problem whether financial or human, as governments invest inadequately in facilities, medicine, equipment, and wages for trained health care staff to work in remote rural areas. And many national health budgets have shrunk as more money is allocated to military spending, with the India being one example of this. Health sectors reforms have also impacted the health systems of rural areas. Health sector reforms refer to the various changes (e.g. user fees, decentralization, priority setting) in health systems and they are promoted globally, but especially in developing countries, starting in the early 1990s. A global shift was felt from universal health care to highly selective health care tied to a global economic agenda. Issues erupt for poor rural women because private health care providers have a strong incentive to tailor their services to meet patients’ preference, so as to retain more clients, but these same providers may not serve the poorest citizens, provide a full range of services or reach remote rural areas. As well, alternate approaches to finance such as user fees, insurance schemes and provider payments may deprive poor rural women of essential services (Tania, Rao and Lori: 2003).

Governments in crafting health policies and programmers need to adopt a rights based, gender sensitive, and women and adolescent friendly approach to health. Women
in India generally have less political representation and less education than men, so their role in public policy debates has been scant; and rural women, facing the most serious sexual and reproductive health problems, are unfortunately the least likely to have a public voice in making decisions about design and implementation of programmers and services. Women are rarely consulted on “… where they prefer to give birth, what support they need for their choices, what happens when they seek help, and what their experiences have been in seeking abortions.” It is imperative that rural women’s health in India as understanding the obstacles that rural women face in achieving their right to health is formative in establishing a plan to erase such barriers (Rayindran: 2005).

Rural women in India is among the most disadvantaged people in the world in terms of their health status and access to accurate and appropriate health information and comprehensive, adequate and affordable health services (Racheral: 2006) Sexual and reproductive health is a particular concern for rural women, as a host of social, cultural, political, and economic factors increase rural women’s vulnerabilities to pregnancy - and childbirth-related deaths and disabilities, unsafe abortion, HIV/AIDS, and reproductive cancers. Closely related to this, are the personal, relational and institutional barriers to rural women achieving their fundamental sexual and reproductive rights, their right to exercise control over their bodies and sexual and reproductive lives, which encompasses their right to decide upon such issues as contraception, marriage and abortion (Soloman, et al: 1998). Further, their overall health status is diminished by the lives they are forced to lead- lives that pivot around the harsh realities of malnutrition, illness, injury, and fatigue, frequently the consequence of long hours of demanding physical labour in unhygienic and dangerous conditions; the strains of childbirth and caring for multiple children; and not having enough to eat, which is often the result of more and better food going to male household run real women given their unmet need for contraception, poetry, proximity from clinics, and limited education, are vulnerable to using services that are not safe. Restrictive national abortion laws, such as also compound this vulnerability, making access to safe abortion services virtually impossible.

In India, for example, according to the Ministry of Health and Family Welfare (1999), only 538,000 out of the estimated 6.7 million pregnancy terminations occurring annually are performed by registered providers in licensed facilities. Rural women in
India, lacking in resources and knowledge of the law, are less likely than their urban counterparts to have a safe abortion. Although data is limited in India, approximately 20,000 deaths (about 18 per cent of all pregnancy-and childbirth-related deaths) are believed to be related to unsafe abortions, with most occurring among the poor, rural women. Uttar Pradesh, with an estimated 68 induced abortion per 1,000 married women of reproductive age per year, is a state that has one of the country’s highest incidences of abortion, reflecting the fact that only 18 per cent of rural married women of reproductive age use modern contraception (Ganatra & Rao: 1998).

Disparities between rural & urban areas to access health care services were alarming. The State invested only 0.52 per cent of its GDP on health care in 2005-06. Rural health centers, particularly the Anganwadis could not provide the needed health care to rural women and children because of insufficient resources. Between 1991-92 & 2005-06 in Himanchal Pradesh, institutionalized births increased from 17 per cent to 45 per cent & births attended by health care personnel increased from 25.26 per cent to 50.2 per cent. However, the number of anaemic pregnant women also increased from 21.8 per cent in 1998-99 to 37 per cent in 2005-06. About 40 per cent of women did not receive adequate antenatal care. In Chhatisgarh 48 per cent women did not receive pre-natal care from anyone, whereas 34 per cent received it from doctors & 12 per cent at home from health workers. While 14 per cent married, women did not avail the antenatal check-ups for economic reasons, 10 per cent cited reasons as customary or family did not allow. In 1998-99, only 8 per cent deliveries took place in the care of health professionals in rural areas. Hospital women used antenatal services less than urban women. MMR of 452 in Bihar was high. The birth rate was 32.1 per cent & the mortality rate was 10.2 per cent. Traditional Dais assisted 65.8 per cent women for child delivery. Women adopted family planning measures more than men. About 9.2 per cent women adopted surgical methods against 1 per cent men; only 0.7 per cent adopted the use of condoms for family planning.

Most rural health centers had inadequate specialists, medical equipment and drugs. Survey by India Today (2005) ranked Bihar the lowest among the big States in terms of primary health infrastructure. In Tamil Nadu 40 per cent maternal deaths were caused by hemorrhage. Mothers who received postnatal care from skilled health care personnel within two days of delivery of the last birth accounted for 89.6 per cent as
against 26.4 per cent in India. In 2005-06, skilled health workers assisted 93.2 per cent mothers for delivery as compared to 48.2 per cent in India & 90.4 per cent births took place at recognized institutions. The reduction of MMR also required tackling maternal anemia since anemia accounted for 12 per cent of all maternal deaths directly and indirectly. MMR in West Bengal declined from 266 to 194 during last five years. In 2005-06, skilled professionals attended 36.8 per cent births in rural areas as against 80.2 per cent in urban areas.

(D) WOMEN AND FOOD:

The sex bias in nutrition or the male against female infants, girls and women, has been brought out by several studies. Girls enter into marriage and motherhood from their pre-existing malnutrition and impair their health from pre-existing malnutrition and impair their health. Cultural traditions of intra-family distribution of food rooted in rural areas compel women to eat least and often eat last both in quantity and quality. While the low nutrient intake may help to maintain her own health and nutritional status, such as it may be the demands on the body during pregnancy and lactation drastically deplete her already scarce reserves leading to entrenched deficiencies and ill health. This is equally true in urban as well as rural areas. Economic betterment has been a tremendous capacity for improving the health, in fact much more than the advancement of medical sciences. It is not only the intake of food, but also the norms of eating that are also important for good health (Nagla: 1999).

In terms of allocation of food, between adults and children are in normal circumstances both fair in terms of relative requirements, and rational in terms of welfare and survival of the family unit. Abdullah found seasonal changes in individual food consumption, with the reduction suffered by children being given less in proportion to their requirements than those of adults (Abdullah: 1983). Preferential allocation of food to male adults may be rational where financial returns, in terms of higher wages, of improved nutrition male, far out weigh those women. A study of rural households in South India found the returns to improved nutrition of men in terms of higher wages to be greater than those for women (Ryan: 1982).
The frequent failure of special nutrition Programme aimed at nutritionally vulnerable groups such as pre-school children and pregnant and lactating women may be a result of the diversion of added food supplies to male household members in order to generate increased wage income. In Devarishikuppam, in South India, men are usually served first and when they have eaten the children are given food followed by the women (Gulati: 1981). Food and health are intimately bound up in local culture. According to local beliefs, one of the most common causes of diseases is the consumption of the wrong type of food. Women’s health and nutritional status is inextricably bound up with social, cultural, and economic factors that influence all aspects of their lives, and it has consequences not for the women themselves but also for the well-being of their children (particularly females), the functioning of household, and the distribution of rescuers.

(E) WOMEN AND NUTRITION:

From the nutritional standpoint, India is a dual society consisting of a small group of well-fed people, and a very large proportion of malnourished and undernourished people. Malnutrition is particularly severe among women and children, especially in the lower classes. 1 to 2 per cent of children below five years are estimated to suffer from protein-energy malnutrition. Iron deficiency i.e., anemia is seen in almost 50 per cent of children below the age of five years, and in 30-43 per cent of women during the age their reproductive period of life. A vitaminoses, particularly exophthalmia leading to blindness and endemic goiter are among the important nutritional problems in the country (Census of India: 1981).

Poor nutrition is not only food and poverty problem but also socio-cultural problem of women in Indian society. It cannot be denied that poverty is major causes of malnutrition and under-nourishment of women. Moreover, it’s more unfavorable socio-cultural values operating against women in distribution of food. Optimum standard of nutrition is determined on the basis of body weight, sex climate, and nature of the work performed. More than half of the women in India do not get the recommended dietary intake of nutrients (Kulkarni: Mimeo undated). Generally, the poor nutritional status of Indian girls and women is part of a vicious cycle that has particularly devastating consequences for pregnant and lactating women and their infants. Malnourished women
were more likely to give birth to low-birth weight babies, and if the under-weight baby is a female who survives, she in turn is likely to continue to be under-nourished throughout her childhood, adolescence, and adult life. This lack of nourishment has detrimental effects on her reproductive and lactating capacities.

All nutritional programmes are directed towards the needs of pregnant and lactating mothers. However, in spite of these programmes, there is nutritional deficiency in women starting from infancy to pregnancy and then again after crossing the child-bearing age. It cannot be denied that poverty is a major after crossing the child-bearing age. It cannot be denied that that poverty is a major cause of malnutrition and under-nourishment. But its more unfavorable impact on women’s nutritional standards shows the connivance of poverty and socio-cultural values operative among them. Poor nutrition of girls, especially in childhood and adolescence, has serious consequences (Jejeebhoy: 1994).

Anemia is a major health problem among India women. A recent population-based survey of pregnant had severe anemia. An analysis of the data from the referral hospital for the area revealed that severe anemia contributed, directly or indirectly, to 35 percent of all in-hospital maternal deaths (Sarin: 1995).

Poor nutrition becomes evident among females during infancy, persists through childhood, and trends to increase with age. The NNMB surveys (1980) documented low intakes of Vitamin A and iron among girl children and adolescents. Vitamins A deficiency is likely to be firmly linked to high mortality and morbidity in children, and to be an underlying cause of high levels of respiratory and genitourinary tract infection in women. Among many Indian families, the largest share of food is usually given to the bread earner, the next to boys, to the old or sick and the last, to young girls and women in the household (Nagla: 1999). Girls are often neglected in matters of feeding and health care. Discrimination in feeding may begin soon after birth as girls are breast fed less frequently and for shorter duration than boys. In recent years, increasing attention has been given to differentials in the allocation of food to women within households. However rates of malnutrition among children and women are high. Ethnographic
literature suggests that female is not fed as well as males in Northern India (Harriss: 1966; Miller: 1981).

Studies in Uttar Pradesh (Khan and Others: 1989) indicate that female children are discriminated when it comes to the allocation of food within household. Marked differences exist between what is fed to boys and girls, the discrepancy increases with age. According to figures obtained from the National Nutrition Monitoring Bureau, in the age-group of 10-15 years, boys are fed 31 gm of pulses a day. Girl gets only 25 gm a day. As a boy grows and takes a sedentary or active job, the gap in the degrees of nutrition widens even more. For instance women in a sedentary job get 403 gm of cereals a day. A man in a similar job gets 475 gm. (NNMB: 1980).

The malnutrition prevalent in a proportion of adult Indian women can be attributed primarily to inadequate food intake. The households theoretically have enough food, but the way it is distributed may leave women inadequately nourished. Typically, adult men and male children are fed fist. Women eat only after the men have finished, and a young wife must allow her mother-in-low to eat first. Whatever is left is divided among the young mother and her female children (Caldwell, Reddy and Caldwell: 1989).

Patterns of health care between individuals–dependents and contributors, within the household may involve trade-offs which have both short and long-term implications for the household. Prefer entail allocation to contributors may be seen as protecting the current entitlement. If this bias, however, is sufficiently pronounced to constrain the growth of dependent child, the long-term exchange entitlement of the household may be adversely effected through the cumulative effect of such constraints on their stature and productivity as adults.

A women’s nutrition and health status in adolescence, per-pregnancy and during pregnancy, childbirth and there after, as well as of prenatal and neonatal mortality and low birth weight, poor nutrition and health also levels of anemia ((Das Gupta, 1987; Khan et al., 1988; Srikantia: 1989). Nutritional status and growth levels in childhood determine age at menarche and adolescent and adult weight and height: in India less than 38 kg and 39 per cent are less than 145cm in height (Gopalan, 1989; Ramachandram: 1989). During pregnancy, malnourishment can increase. Belief and practices during
pregnancy in much of India tend to encourage ‘eating down’ that is, reading women’s already meager average daily food intake and discouraging the intake of nutritional items, such as leafy vegetables, during pregnancy (Nag, 1994; Ramachandran: 1989). Even when women are aware of the importance of a nourishing diet during pregnancy, cultural and economic constraints deny them access to better nutrition (Khan et al: 1988).

Pregnant women experience high rates of anemia. Studies indicate that 40-50 per cent of pregnant women in urban areas are anemic (Mathai, 1989; UNICEF: 1991). Levels of anemia are higher in such states as Bihar and Uttar Pradesh where feeling beliefs in ‘eating down’ inhibit adequate diets among women (Agarwal: 1987), and rural areas where hookworm infestation is endemic (Ramachandran: 1989). A better strategy would be widen the focus of the Programme and provide micronutrient supplements and nutrition education to adolescent girls and all women rather than only those who are pregnant (Pachuri: 1995). The consequences of maternal anemia for infants are equally acute in terms of prenatal mortality, low birth weight and failure to thrive (Mathai, 1989; Ramachandram: 1989). Moreover, women’s poor health and nutrition’s status can also lead to repeated miscarriages, fetal wastage and infertility.

The conflict between women’s (economic) earning role and (biological and social) mothering role results to some degree in a squeeze on child care, with consequences for child health and nutrition. Within the household, women play an important part in health care. They are responsible for water supply, environmental hygiene, food preparation, and preventive health activities. The exceptionally high rates of malnutrition in South Asia are rooted deeply in the soil of inequality between men and women. Malnutrition is far worse in South Asia that is in India, directly due to the fact that women have less voice and freedom of movement. Judgment and self-expression and independence largely denied millions of women have neither the knowledge nor the means and the freedom to act in their own and their children’s best interests.

Gender disparities in nutrition are evident from infancy to adulthood. In fact, gender has been the most statistically significant determinant of malnutrition among young children and malnutrition is a direct or underlying cause of death among girls below age 5. Girls are breastfed less frequently and for shorter durations in infancy; the
diet in childhood of males is better than female child. Adult women consume approximately 1,000 calories fewer per day than men according to one estimate from Punjab. Comparison of household dietary intake studies in different part of country shows that nutritional equity between males and females is lower in northern than in southern states (Coonrod: 1998).

Nutritional deprivation has two major consequences for women: they never reach their full growth potential and are anemic. Both are risk factors in pregnancy, with anemia raging from 40-50 per cent in urban area to 50-70 percent in rural area. This condition complicates childbearing and result in maternal and infant deaths, and low birth weight infants. One study found anemia in over 95 percent of girls ages 6-14 in Calcutta, around 67 percent in the Hyderabad area, 73 percent in the New Delhi area, and about 18 percent in the Madras area. This study states, “The prevalence of anemia among women ages 15-24 and 25-44 years follows similar patterns and levels. Besides posing risks during pregnancy, anemia increases women’s susceptibility to diseases such as tuberculosis and reduces the energy women have available for daily activities such as household chores, child care, and agricultural labor. Any severely anemic individual is taxed by most physical activities including walking at an ordinary pace (Tinker & Anne: 1996).

SECTION-III

Women constituting around half of the population play a distinct role in the development of our nation. As a mother, she shapes the personality and character of her children and thereby the character of the nation. As a housewife, she maintains the productivity of the human capital within her household through proper home management. Apart from this, a woman herself represents a unit of human capital and is therefore capable of contributing to the economy of the nation. Thus, unless women are mobilized towards contributing to the national development and growth, the nation is only half way towards development. It is a fact that women cannot contribute meaningfully in the process of development, until their own development is taken care of. Though, women in the urban areas have excelled in all fields-political, social and
economic the rural counterparts are denied even the basic amenities like health and education.

(A) CONCEPT OF HEALTH:

Health is defined by the World Health Organization (WHO) as a state of complete physical, mental, and social well being and not merely absence of disease or infirmity. This definition was accepted by all the signatories to the Alma-Ata Declaration on health adopted by the thirty-first World Health Assembly in 1978. This declaration gave the call of ‘Health for All by 2000 AD’ and accepted that Primary Health Care was a key to attaining this goal. Health systems are too often being devised outside the mainstream of social and economic development. These systems frequently restrict themselves to medical care, although industrialization and deliberate alteration of the environment are creating health problems whose proper control lies far beyond the scope of medical care (Tejada-de Rivero: 1981). Health is thus not only about disease and medical care system but also about the environment around us, which influences the mental and physical state of a person. It is multidimensional phenomenon (Hema and Muraleedharan: 1983). The ‘basic needs approach’ considers health as a basic needs along with food, clothing, shelter and education starting from pious, basic needs approach is utilitarian, “because fulfillment” of basic needs “contributes to utility” (Sen: 1985). Many subsequent researches also have built on the concept of health as a utility. For example, World Development Report 1993 considers good health as an input for increasing productivity, leading to economic growth. The National Council of Applied Economic Research considers health status as “an important indicator of the level of economic development” and it includes mainly mortality and morbidity (NCAR: 1992). However disagrees with this utilitarian approach. He argues that, the “value of the living standard lies in the living” and better health living and not on instrument for better living (Sen: 1985).

(B) CONCEPT OF NUTRITION:

Nutrition is the science that deals with all the factors related to food and the way in proper nourishment is brought about. The intake food and supplements in the body is utilized for maintaining health and energy. This is made possible with the basic nutrients available in the food. The good food mainly consists of macronutrients which includes
water, fats and proteins whereas the micronutrients include vitamins and minerals. All these are very essential factors for normal functioning of the body. The average nutritional requirement for different groups of people entirely depends on age, sex height, weight and degree of activity and rate of growth. Food taken in any form either solid or liquid supplies the body a means to produce energy of any from. The available nutrition in the food promotes growth, maintenance of the body. Proper nutrition is only possible when the diet taken is balanced and the food consumed has all the basic nutrients (Indian women health. Com Nat ration on line net: 2011).

Malnutrition is another serious health concern that Indian women face. Although, malnutrition in India is found among all segments of the population, poor nutrition among women in childhood continues throughout their lives without full physical development. According to the NFHS-3 Survey, mother’s education plays a significant role in deciding the level of malnutrition among her children women. Malnutrition among women is further exacerbated or compounded by heavy work demands, nutritional needs, eventually culminating into increased susceptibility to illness and consequent higher mortality (Khan: 2011).

(C) THEROTICAL FRAMEWORK:

Impressive achievements and intolerable shortcomings characterize India’s health Programme over the past fifty years. On one hand, there has been a decline in mortality rates; life expectancy and infant survival conditions have improved over a period of time. It is very high when we compare the infant mortality rate with other with countries. The World Bank Report notes that public health financing in India is characterized by an emphasis on hospital, rather then primary care; urban rater rural population; medical offices returns; and family planning and child exclusion of wider aspect of only perpetuated but have been accentuated (Nagla: 2003). The status of women is a complex issue. It is not amenable to any simplistic explanation of social reality. Literature on the status of women has been varied and all of them have been addressing the key issues affecting the women in various areas of development. Though the areas of development, political, social, legal, health etc. The constitution of India provided equality to women. The introduction of adult franchise along with the removal of all discrimination on sex
Introduction

Ground, provided towards the complete emancipation of women. But the inequalities inherent in traditional structures have a significant bearing on women in different in traditional structures have a significant bearing on women in different spheres of life.

The International Conference on Population and Development in Cairo in 1994 placed Reproductive Health at the Centre of Stage of demographic objective instead of fertility reduction. The Cairo Conference recognized women’s rights as individual reproductive rights. Gender equality infant, child and maternal mortality reduction; and provision of universal access to reproductive health services, including family planning services are some of the area for achieving the gender equity which is necessary to reduce the threat to women’s health.

Conceptualization of health may be found to very systematically among social groups, put it is likely that different accounts are variously drawn according to social circumstances and that people’s idea will change over time. People are likely to work with unified theories or explanations, which transcend time and place and are more likely to have views which, adjust according to the concerns of the individual. We must therefore, be careful when making inferences on the basis of people’s accounts, which are invariably retrospective rationalizations, constructed for the purpose of the interview. Thus, we see that people hold a multiplicity of accounts about health and illness, and this is hardly surprising given the multifaceted nature of people’s live and lifestyles (Drummond and Mason: 1990). The sociology of women’s health derived by synthesizing these theories produces a number of counter initiative findings, which can be summarized.

(D) THEORY OF CULTURAL DUALISM:

Women are a culturally constructed gender category rather than simply a biologically sex category. This argument led to a much broader feminist challenge to existing knowledge of the relations between men and women. Ortner (1982: 490), in an ambitious attempt to avoid biological determinism while still explaining women’s subordination as a universal phenomenon, asked what it was that would lead every culture to place a lower value on women than men. She concluded that every society made a distinction between nature and culture. Drawing on the work of Simon de
Beauvoir and Chodorow, she argued that those women’s social ties to children through pregnancy and breast feeding ensured that women appeared to be closer to nature than men. Simon de Beauvoir is one of the chief protagonists of cultural dualism (Simon de Beauvoir: 1952: 22). It is based on the perception that the secondary subordination in part, in her relationship to nature and nature’s relationship to culture. Man control nature through culture, so he is superior to nature. Elaborating the perspective of cultural dualism, Whyte and Whyte (1989) view that the western women seek greater satisfaction by the improvement of her family’s economic situation and of her status within family. The primary role of the women is always manifested in their family. The society at large views their economic role as secondary so that they are pushed out of the market. Though cultural dualism lacks coherence, it provides a useful analysis by supporting a sophisticated view of the internal dynamics of culture as it relates to the position of women.

(E) DEVELOPMENTALISM PERSPECTIVE:

The perception that modernization has had differential effects on men and women has led planners to seek to describe the obstacles preventing women from participating in development. The United Nations Conference on women held in Mexico City, in 1975, focused worldwide attention on the need for “intensified action to ensure the full integration of women in the development process” (United Nations: 1975). The developmentalism perspective presented at the UN Conference has outlined three notions about social change that differ from the assumption of conventional modernization theory: (a) changes introduced in one sector may not generate compatible changes in various other sector of society; (b) there are always contradictions in the process of social change; (c) national elites and external forces play major role in ushering in programmes aimed at social change favoring women. Failures in implementation have led revisionist developmentalist to consider decision-making by individuals as well as governments.

(F) BIOLOGICAL PERSPECTIVE:

Perhaps the most influential and controversial theory of the emergence of gender identity is that of Sigmund Freud. According to him, the learning of gender differences in
infants and young children is centered on possession or absence of male sexual organs. Freud is careful to say that it is not just the anatomical distinctions that matter but possession or absence of male sexual organ is symbolic of masculinity and femininity. Physical differences between a man and woman become the basis of building a system of reciprocal roles and in the process the wife’s role including the nurturing subordinated while the economic functions of man was defined as superior and super-ordinate and boys and girls are socialized to fulfill the roles. However, the division of roles between the sexes has its origin in the biologically different functions of males and females. But this does not mean that man is biologically the more active one or he is biologically determined reproductive difference between the sexes.

**(G) MARXIAN PERSPECTIVE:**

Marx has not exclusively dealt with the theory of women’s emancipation. Of course, one finds new references in the works of Marks about family, about changing sex relations and about the importance of the female as an economic production unit in the social organization of society until the capitalist (bourgeoisie) society came into being. In the Communist Manifesto, Marx and Engels predict the dissolution of the family in its old form (not only of the family) but all pre-capitalist form of exploitation and oppression visualize those who have no access to the means of production will be ruled by the laws of motion. Engels traced the link between the rise of private property, monogamy, patriarchal family and the state (Engels: 1970). This was an attempt to show the origin of sub-ordination of women by men and based on that locating determination of women’s subordination analytically. Engels present historical process by which women are transformed from free-equal productive members of the society to subordinate and dependent wives (Engles: 1970).

**(H) PRESPECTIVE OF PATRIARCHY:**

The word patriarchy literally means the rule of the father or the “patriarch”, and originally it was used to describe a specific type of “male-dominated family”. This refers to the power relationship by which men dominant women, and to characterize a system whereby women are kept subordinate in number of ways (Bhasin: 1993). The conception of patriarchy as universal and is logically based on the conception of women as a
universal category. Whether or not women are explicitly conceived of as a class whose interests are opposed to those of men as a class (a position taken, for example, by Firestone (1979) and Millett (1977), men are seen as having and defending power over women. Thus, patriarchy has been used by feminist scholars as a theoretical construct to explain the structure underlying the subordination of women and as one hindering the development of women. The structure of the patriarchal system has been conceived at psychological, cultural and material levels. The centrality of the family (which is a primary unit) is an entity in which the productivity activities are undertaken. This unit in which the production and reproduction of social life is carried on has definitely a major role in the development of women. Women’s experience within the household varies by class, ethnic group, caste, culture and religion. It is thus necessary to explore the differing principles and notions of family and position in the society. The process of socialization starts from this basic social unit i.e. the family (Mitra and Mukherji: 1987). So, here start the process of subordination.

Beside the above theoretical explanations of women’s subordination at global level and in the Indian Society, the roles women play in the society and the images of them developed, are not simply from exigencies of biology and social situations, but are rather deeply rooted in the myths, legends, religion and culture. Therefore, it is clear one observes that the underlying causes keeping women in subservience as “second sex” are devoid of any identity. This tradition has gained much significance and with the passage of time came to be accepted as the unwritten law of the land. Moreover, the demographic indicators like mortality rate, infant mortality rate, life expectancy, reproductive diseases will be able to spell out the prevailing inequality among males and females.

A theoretical approach to the problems and prospects of women’s development is extremely essential to have a thorough understanding of the subject. Laws by themselves cannot bring social structure, and role of the productive process. One assumption to all the perspectives is that the position of women has not registered significant improvement despite the efforts at modernization. Many feminist scholars have used patriarchy as a theoretical construct to explain sexual inequality and as one hindering to the development of women.
SUMMARY:

Health care system in India, found a concern in ancient India has evolved though ages with many ups and downs. Indian systems of medicine like Ayurveda and Siddha were added with Unani system during Muslim period and then with European Allopathy system during the British rule, India become a sovereign independent state and the health infrastructure was not available at that time to the masses. After independence various health infrastructures, health manpower and focus to specific priority areas are planned and implemented on recommendations of various review committees through the different five year plans. Strategies for epidemic and emerging diseases are of major concern. Women, though most important section of society, were largely ignored especially in rural India for heir health concerns.

Uttar Pradesh is one of the largest, densely populated, and backward states of India which has a socio-economical and thus health related problems for women. To understand the real challenges micro level sociological studies are urgently needed. This thesis analyzed health scenario and its related issues and challenges in a rural pocket of distantly located backward district of Uttar Pradesh. No such study is available with sociological perspective for understanding the concern of women.