Social Determinants of Urban Indian Women’s Health Status

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KEYWORDS: INDIAN WOMEN, HEALTH, SOCIAL DETERMINANTS, POVERTY, VIOLENCE

Indian urban women have come a long way regarding careers and social standing. However, they still remain unaware of their personal well-being and health needs. Often, they ignore their health problems until the problems become unavoidable, chronic or even fatal. The present paper focuses on the determinants of women’s health in urban India, including accessibility of health services, education, gender, class and geographical location, employment, availability of services, social history and culture. The paper also suggests some changes required in policies for improving urban women’s health in India.

Background

Vandana Mishra, states “I am a natural winner and I had always believed that nothing but the best can happen to me! If only I had thought that even I can be sick. If only I had known that cancer will not spare me despite my looks, my fitness, my job and pay packet. If only I had taken some time out for myself” (Uterine Cancer Stage III patient) (Biswas, 2010). Health status is no longer considered an outcome solely of lifestyle choices. It is now believed that health is also influenced by social, political and economic factors. The sum-total of these factors are called the determinants of health. The current understanding of women’s health has gone beyond singular, individual, biomedical perspectives to include diverse factors such as the family, community, population, psychosocial, and cultural understandings. Social determinants of health also include such factors as education, income, employment, working conditions, environment, health services, and social support (Wuest et. al., 2002).

The Universal Declaration of Human Rights(Article 25) states that, “Everyone has the right to a standard of living adequate for the health and well-being of him/herself and his/her family, including food, clothing, housing and medical care and necessary social service. Everyone has the right to education” (What is Foreign Aid, 2010). According to the World Health Organization, “Health is a state of complete physical, mental, and social well-being and not merely the
absence of disease or infirmity”. “Good health requires provision of health care for prevention and treatment of disease and injury, good nutrition and a safe environment. The health of populations has many links with other sectors, such as economic, education, water and sanitation and gender” (Health, 2010). With the world ready to move into the 2nd decade of the 21st century, there is a phenomenal rise in the number of people living in urban areas. The urban population in the continents of Asia and Africa alone is expected to double in a period of 30 years (Earthscan, 2005).

With its over a billion population, India has also witnessed the growth of urbanization, similar to other regions in Asia. In fact, India’s urban population is increasing at a faster rate than its total population. It is predicted that 41% (575 million people) of India’s population will be living in cities and towns by 2030, from the present level of 28% (286 million people). There is a close link between economic development and urbanization. Cities in India contribute over 55% to India’s Gross Domestic Product (GDP) and urbanization has been recognized as an important component of economic growth (UNDP, 2009).

Urban Poverty

According to estimates of National Planning Commission of India, about 26% of urban population in India is living below the poverty line (Planning Commission, 2007). Using a human development framework, India’s Urban Poverty Report provides many insights into various issues of urban poverty, such as lack of basic services to urban poor, migration, urban economy and livelihoods, micro-finance for the urban poor, access to education and health, and the unorganized sector (Urban Poverty in India, 2007).

It is interesting to note that the ratio of urban poverty in some of the larger states is higher than that of rural poverty in some of the smaller states. This is called the phenomenon of ‘Urbanization of Poverty’. Urban poverty correlates with problems of housing, clean water, sanitation, healthcare, access to education and social security. In the continuum of urban poverty, special needs of vulnerable groups like women, children and the aged are paramount. Poor people live in slums which are overcrowded, often environmentally polluted and lack basic civic amenities like clean drinking water, sanitation and health facilities. Most of the slum-dwellers are involved in informal sector activities (such as begging, selling used items in street corners, vending food items), where there is a constant threat of eviction, displacement, confiscation of goods and almost non-existent social security coverage (India: Urban Poverty Report, 2009).

Along with other challenges, slum-dwellers also face the constant threat of forced eviction. A forced eviction refers to “the
involuntary removal of persons from their homes or land, directly or indirectly attributable to the state,” with either government assisted or unassisted relocation (Fact Sheet No.25, 1996). Forced evictions are common, and have been documented in several countries including Bangladesh, India, Kenya and Thailand. For example, residents of the Ambedkarnagar slum in Mumbai experienced eviction 45 times during a 10-year period. These evictions included destruction of some or all of the dwellings. The resettlement areas provided lacked basic infrastructure such as water and sanitation (Ompad et al., 2008).

**Social Determinants of Health (SDH)**

Social Determinants of Health are the conditions in which people live and work, and these conditions affect their opportunities to lead healthy lives. In March 2005, the World Health Organization set up a Commission on the Social Determinants of Health (WHO, 2005). The commission listed determinants like child development, gender, urban setting, employment, health system, measurement and evidence, globalization, and social exclusion, as central to tackling the prevailing inequalities of health in the world (Labonté & Schrecker, 2007). The final report of the commission concluded that growth alone is not sufficient to achieving health equity, the distribution of health services is equally important. The three important pillars of action according to the report are: 1) improve the conditions of life and the circumstances in which people live and work, 2) address the inequitable distribution of structural drivers—power, money and resources—at the global, national and local levels, and 3) measure the problem, evaluate the actions and address the issue of human resources through which health services can be delivered (Nayar & Kapoor, 2007).

On the basis of the recommendations of the CSDH, the 62nd World Health Assembly, requested the Director-General of WHO to make social determinants of health a guiding principle, while taking into consideration the progress on objective indicators for monitoring the social determinants of health. The Assembly also recommended that the Director-General give priority to addressing social determinants of health, support the member states in promoting access to basic health services, provide support to member states in implementing a ‘health-in-all-policies’ approach to tackle inequities in health (Eighth plenary meeting, 2009).

It is an accepted fact that basic health-care, family planning and obstetric services are essential for women, yet these facilities remain unavailable to millions of them in the developing world. Moreover, many believe that the health of families and communities are tied to the health of women. The illness or death of a woman has serious and far-
reaching consequences for the health of her children, family and community (The Importance of Women’s Health, 2005).

Women’s Health in India

In India, gender-based health indicators have shown improvement over time, however, these developments are still far from optimal. In comparison to the European states, the difference in gender-based indicators is enormous. For example, among cause-specific mortality rates, maternal mortality rate in India is 16.6 times, TB among the HIV positive population is 2.8 times, and age-standardized mortality rate from non-communicable diseases is 1.2 times the comparable rates in Europe. Only the incidence of cancer in India is significantly lower than in the EU (WHO, 2009).

Indian Urban Women’s Morbidity

The health of Indian women is linked to their status in society. The society is patriarchal, and there is a strong preference for sons in India. This bias sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. Typically, they have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons (Velkoff & Adlakha, 1998). To gain a better perspective on the health status of urban Indian women, it is important that we look at some of the selected diseases from which women frequently suffer, and compare them with the prevalence rates amongst their rural counterparts, and also compare them with men.

Diabetes, Asthma & Goiter

In cases of diabetes, asthma and goiter, urban women do worse than their rural counterparts. Also, women suffer from goiter more than men, both in rural and urban areas, by about 1.93 and 3.62 times, respectively. Moreover, urban women suffer more from asthma than their male counterparts (Sengupta & Jena, 2009).

Cancer

Though the incidence of cancer is still low in India compared to that of developed countries, incidence of breast and cervical cancer is becoming increasingly significant. According to the National Sample Survey (NSS, 2004), out of every 1000 women, 33 in urban areas and 39 in rural areas were hospitalized due to cancer.

A recent survey done by WHO reveals that every year 132,082 women are diagnosed with cervical cancer and 74,118 die from the disease. In fact cervical cancer ranks as the most frequent cancer among women in India. (Are you putting yourself last, 2010).
HIV/AIDS

Lack of gender-sensitive education is also leading to new infections such as HIV/AIDS and other sexually transmitted diseases (Pramanik, Chartier & Koopman, 2006). HIV prevalence in India among adults is estimated at 0.8% (4.58 million) in 2002. Out of these, women constitute 25% of the reported cases. The spread of HIV infection is not uniform across the states. Six states, Andhra Pradesh, Karnataka, Nagaland, Manipur, Maharashtra and Tamil Nadu, have been categorized as high prevalence states. Differences in power between men and women are a major cause of the spread of HIV/AIDS among women. Pressures of migration, violence against women including trafficking and domestic violence, are manifestations of this problem, which in turn, subject women to HIV/AIDS infection risk. Lack of information and denial of access to safe practices during sex are additional reasons for the current situation (Mitra, 2009). Also, in general, Indian women have little power to negotiate the conditions of sex with their partners, both in and outside of marriage.

Malnourishment

Undernourishment among women in India is high. In the Global Hunger index calculated by IFPRI (2008), India ranks 66th among 88 ranks (higher numbers show hunger). India also scores 23.7 with an ‘alarming’ hunger incidence (Gandhi, 2009). Women’s nutritional levels are lower than men since women face discrimination right from the time of breastfeeding to their adulthood (Pandey, 2009).

Anemia

According to estimates, 25-30% of Indian women in the reproductive age group and almost 50% in the third trimester are anemic. One study found anemia in over 95% of girls aged 6-14 years in Calcutta, around 67% in the Hyderabad area, 73% in the New Delhi area, and about 18% in the Madras area. This study states, “the prevalence of anemia among women ages 15-24 years and 25-44 years follows similar patterns and levels” (Social empowerment, 2009). Anemia increases women’s susceptibility to diseases such as tuberculosis and reduces the energy women have available for daily activities such as household chores and child care (see Table I for prevalence rates of anemia in urban women). In some states such as West Bengal, Orissa, Bihar, Assam and Arunachal Pradesh, between 63 and 85% of married women suffer from anemia (IIPS & ORS Macro, 2000).
Table I: Percentage of Women with Any Form of Anemia in India 2005-2006

<table>
<thead>
<tr>
<th>Maternity Status</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant</td>
<td>58.7</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>63.2</td>
</tr>
<tr>
<td>Neither</td>
<td>53.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residence</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>50.9</td>
</tr>
<tr>
<td>Rural</td>
<td>57.4</td>
</tr>
</tbody>
</table>

Source: NFHS-3, 2005-06

Inter-state & Regional Variations in Urban Women’s Health

There are wide variations among cultures, religions and levels of development among India’s 25 states and seven union territories. Hence, women’s health also varies greatly from state to state (Chatterjee, 1990; Desai, 1994; Horowitz & Kishwar, 1985; The World Bank, 1996). India is a massive country in terms of its diversity and cultural practices. Availability and utilization of reproductive and child health services from state to state widely differ. It is essential to understand the extent of poor and non-poor disparities in urban areas across the states irrespective of their urban poverty (Kumar & Mohanty, 2010). Son preference is very strong in states like Uttar Pradesh, Bihar and Rajasthan, which leads to larger families as couples continue to have children until they reach their desired number of sons (Singh, 2003). In the state of Haryana, the sex ratio in the 0-6 year group hit a five year low of 834 girls for 1000 boys. Traditionally a patriarchal region, the gender skew in Haryana can be attributed to a strong son preference. Moreover, families misuse and abuse new reproductive technologies to get rid of female pregnancies (Rustagi, 2006; Sev’er, 2008). Haryana is only one of many Indian states to grapple with the menace of female foeticide. Several socio-cultural factors such as landholding patterns, inheritance norms and dowry have tilted the scales against the girl child (Times of India, 2010).

Existing empirical literature on inter-state or regional patterns of gender bias shows girls to be more likely to be malnourished than boys in both northern and southern states (Patra, 2008). “The states with strong anti-female bias include rich ones (Punjab and Haryana) as well as poor (Madhya Pradesh and Uttar Pradesh), and fast-growing states Gujarat and Maharashtra) as well as growth-failures (Bihar and Uttar Pradesh)” (Sen, 2005, p. 230).

The north-western parts of the country are known for highly unequal gender relations. Symptoms of this inequality include the
continued practice of female seclusion, very low female labor force participation rates, a large gender gap in literacy rates, extremely restricted female property rights, a strong preference for boys in fertility decisions, neglect of female children, and a drastic separation of married women from the natal family (Dreze & Sen, 1995).

Table II: Differentials in Health Status Among States

<table>
<thead>
<tr>
<th>Sector</th>
<th>Population BPL (%)</th>
<th>≤5Mortality per 1000 (NFHS II)</th>
<th>MMR/Lakh (Annual Report 2000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>26.1</td>
<td>94.9</td>
<td>408</td>
</tr>
<tr>
<td><strong>Better Performing States</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerala</td>
<td>12.72</td>
<td>18.8</td>
<td>87</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>25.02</td>
<td>58.1</td>
<td>135</td>
</tr>
<tr>
<td>Tamilnadu</td>
<td>21.12</td>
<td>63.3</td>
<td>79</td>
</tr>
<tr>
<td><strong>Low Performing States</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orissa</td>
<td>47.15</td>
<td>103.3</td>
<td>498</td>
</tr>
<tr>
<td>Bihar</td>
<td>42.60</td>
<td>105.1</td>
<td>707</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>15.28</td>
<td>114.9</td>
<td>607</td>
</tr>
<tr>
<td>UP</td>
<td>31.15</td>
<td>122.5</td>
<td>707</td>
</tr>
<tr>
<td>MP</td>
<td>37.43</td>
<td>137.6</td>
<td>498</td>
</tr>
</tbody>
</table>


There are multiple cultural barriers and social evils that influence health which operate at the household and individual levels. These relate to class, caste, ethnicity, religion and gender inequalities. Gender issues are especially important and in India, women and girls face severe discrimination in personal rights (e.g. sexual and reproductive choices) and access to personal services such as education, health facilities and family planning services (Luce, 2006). The intra-household inequalities and discrimination impact the status of women. For example, in tribal societies in India that have a very high incidence of poverty, women enjoy higher social status than their counterparts in other regional groups. However, because of the overall socio-economic position of tribal groups in the larger society, they are still more vulnerable to discrimination and violence perpetrated by those belonging to non-tribal groups (Thukral, 2002). The statistics given in Table II clearly bring out the wide differences between the attainment of
health goals in the affluent states as compared to the non-affluent states. It is clear that national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country. The wide inter-state disparity implies that, for vulnerable sections of society in several states, access to public health services is nominal and health standards are grossly inadequate (National Population Policy (NPP), 2002).

**Reproductive Health Status**

The average Indian woman bears a child before she is 22-years-old, and has little control over her own fertility and reproductive health. Between 1998-1999, only 48% of married women in the reproductive age group used any form of contraception. This figure is much lower (30%) in poorer states like Uttar Pradesh and Bihar. Abortion is the only method of contraception available for many disadvantaged women. More than 570 women die per 100,000 births, and 70% of the deaths are due to easily avoidable causes. Some estimates suggest that more than five million abortions are performed annually in India, with the large majority being illegal. As a result, abortion-related mortality is also high (World Population Monitoring, 2000).

According to National Family Health Survey (NFHS-3, 2005-06), almost 48% of women in India experience some kind of problem during delivery. However, only 50.2% of women giving birth went to a doctor for prenatal care, 22.85% received no prenatal care and 57.6% of women giving birth accessed no post-natal care at all. Almost 27% of urban mothers and 21.55% of rural mothers reported ‘costs too much’ as the reason for not delivering their child in a health facility. Maternal care has definitely improved in India since 1992-93; however, with only 76% women accessing any prenatal care and only 40.85% of births happening in a health facility, there is a long way to go (Sengupta & Jena, 2009).

**Inter-state Variations in Reproductive Health**

For the states of Uttar Pradesh, Rajasthan, Madhya Pradesh, Orissa and Bihar, practice of safe delivery is twice as high among urban non-poor than poor, while the gap is comparatively smaller for the states of Maharashtra, Karnataka, Gujarat, Kerala, Tamil Nadu, Andhra Pradesh and West Bengal. Except Kerala, in every other state the urban poor are more likely than non-poor to deliver outside of a health-care facility. Substantial differences are also observed among urban poor and non-poor in case of prenatal care utilization. These differences cut across the states, irrespective of time. Among the states where deprivation level is comparatively high, the coverage of prenatal care is far from universal, particularly among the urban poor. For example, in case of Uttar Pradesh (17.0%), Bihar (18.5%), Madhya Pradesh (33.2%) and Rajasthan (41.5%)
hardly one third of urban poor women has had access to prenatal care in 2005-06 (Kumar & Mohanty, 2010).

**Quality of Health Services**

Women’s health is also harmed by the poor quality of reproductive services. “About 24.6 million couples, representing roughly 18% of all married women, want no more children but are not using contraception” (Anand, 2005). The causes of this unmet need remain poorly understood, but a qualitative study in Tamil Nadu suggests that women’s lack of decision-making power in the family, women’s lack of control over sexual/reproductive choices, opportunity costs involved in seeking contraception, fear of child death, and poor quality of contraceptive service, all play an important role” (Kumar and Mitra, 2004).

**Health Status of Slum & Non-Slum Dwelling Indian Urban Women**

The slum dwellers experience widespread social isolation, are often illiterate and lack negotiation capacity to demand improved public services. They are particularly vulnerable to the many health risks that occur as a consequence of poor living conditions. Their health indicators are much worse than urban averages and similar to or worse than those of rural populations (Health, 2010).

In a study done on a sample of 4,827 women in the age group of 15–49 years, it was found that less than half the women from the slum areas were not using contraception. Also, discontinuation of contraception rate was higher among these women. Sterilization was the most common method of contraception (25%). The probability of prenatal care visits depended significantly on the level of education and economic status (p<0.05). Also, among slum women, the proportion of deliveries by skilled attendants was low, and the percentage of home deliveries was high. The study also found that women from slum areas depended on the government India’s urban poor live in cramped, low-quality housing with limited sanitation and limited access to affordable and quality health care facilities for reproductive health services (Hazarika, 2010). Two small studies conducted after an eviction in 1998 found stunting, wasting, vitamin deficiencies and infectious diseases in this population (Ompad et al., 2008). These studies suggest that significant differences in reproductive health outcomes exist among women from slum versus non-slum communities in India. Efforts to achieve MDGs (Millenium Development Goals) and other indexes of national or international health need to focus on the urban slum populations.
Indian Urban Woman’s Work in Organized & Unorganized Sectors

Women’s labour force participation rate is 25.6% compared to 57.95% for men (Census of India, 2001). Women contributed only 17.2% of organized sector employment in 2001. There are far fewer women in the paid workforce than there are men.

The lack of appreciation for women’s work—paid and unpaid, productive and reproductive—is an old problem. A pilot Time Use Survey conducted in 1998-99 by the Central Statistical Organisation showed that 51% of women’s work is not recognized as work. About 93% of women workers is in informal employment sectors (including agriculture), or is in low income jobs. Wage gaps between male and female labour persist and are greater in urban than rural India (Government of India, 2005).

In urban areas, where 80% of women’s work is in unorganized sectors like household work, sub-standard building construction and other petty trades, the work environment is hazardous. Moreover, the absence of security and welfare mechanisms make women vulnerable to serious health conditions, rape and other forms of sexual harassment. Carrying and lifting heavy loads often have serious health consequences for women, like menstrual disorders, prolapse of the uterus, miscarriage, and back problems, especially spinal problems (Sarojini, 2006).

Gender-Based Violence

Gender-based violence in the form of rape, domestic violence, honor killing and trafficking takes a heavy toll on the mental and physical health of affected women. Gender-based violence is increasingly becoming a major public health concern in India, and constitutes a serious violation of basic human rights. Every 60 minutes, two women are raped in this country. What is more horrendous is that 133 elderly women were sexually assaulted last year, according to the latest report prepared by the National Crime Records Bureau (NCRB). A total of 20,737 cases of rape were reported last year registering a 7.2 per cent increase over the previous year, with Madhya Pradesh becoming the “rape capital” of the country by topping the list of such incidents (Crime in India, 2007) Delhi is the sexual-crime capital. The inefficacy of India’s rape laws is viewed as one of the reasons for these crimes. A 2005 United Nations report revealed that around two-thirds of married women in India were victims of domestic violence and one incident of violence results in women losing seven working days in the country. “Discrimination against girl child is so strong in the Punjab State of India that girl child aged two to four die at twice the rate of boys” (UNIFEM, 2002).
Gender-Related Educational Disparities

Gender disparities in education persist with far more girls than boys failing to complete primary school. The national literacy rate of girls over seven years is 54% against 75% for boys. In the Northern Hindi-speaking states of India, girls’ literacy rates are particularly low, ranging between 33–50%. While the enrolment rate is high in urban areas, it is conspicuously low in rural areas and amongst the slum and minority communities. The disparity is also regional with a higher literacy rate across the Southern and North-Eastern states, but very low in some of the most densely populated northern states. In Uttar Pradesh, the most populated state in India with a population of 172 million (larger than Brazil, which ranks the fourth most populated country in the world), on average, only one out of four girls is enrolled in the upper primary school. Amongst the marginalized communities in the state of Bihar, the situation is far worse where only one out of every six girls is literate. The national average shows that there are twice as many illiterate women as there are men (UNICEF, 2007).

Psychological Blocks

There are certain socio-psychological obstacles, besides the earlier mentioned external factors, that lead to urban women’s poor health status. The socio-psychological perceptions of most rural and many urban women have been structured and petrified by centuries of patriarchal supremacy and a family system where the father and subsequently the husband is considered as equivalent to God. “The feeling of inferiority has been embedded in their psyche so much so, that far from condemning acts of violence against them, they are more likely to throttle the voices in favor of them. This is part of the clichéd vicious circle of illiteracy and social backwardness that accounts for all the resultant backwardness of the gender” (Bilkis, 2009).

Access to Health Facilities

Apart from poverty, other contributing factors to poor health among the urban poor, is the low awareness and malpractice of recommended health practices. The high cost of health care and low accessibility victimize the poor (Mulgaonkar et al., 1994). Despite the concentration of health-care facilities in urban areas, the access of the urban poor to basic health services is hampered by several factors. The cost of travel may be prohibitive, women may not have anyone to leave young children with and/or slum dwellers may be treated shabbily or overtly discriminated against in health centers. Where free health services are not available, the cost of care may be unaffordable. Access must therefore be broadly defined to encompass its physical, social, cultural and economic dimensions (Document, 2005).
In central and northern regions of the country, health access is poorer, indicating a poor health infrastructure, poor services and low qualification of providers. The larger cities are more effective in providing a better health environment. Larger cities are less prone to rampant infections, communicable diseases like pneumonia or diarrhea. Similarly, cities from southern states of India have healthier populations, while the least healthy are from cities in central India (WHO, 2002).

Due to poverty, many are unable to use health services. The poor hardly seek health-care when they are ill. The poor have to depend on loans and sale of assets—assuming they have assets—to pay for hospitalization. Cost is a greater barrier than the physical access to health providers. There is no provision in the government programs for the unorganised labour sector to access medical benefits while the organised employees often have provisions for medical benefits (Enson & Cooper, 2004).

**Issues About Women’s Empowerment**

There is a strong relationship between women’s empowerment and health. According to NFHS-3 (2005-06), only 27.1% of women in India seem to be able to make a decision about their own health care, while 30.1% of decisions are made by husbands. While 62.2% of women decide on their own or jointly with their husbands about their health care, this seems to improve with education levels (NFHS-3, 2005-06). Only 60.3% of urban women and 41.5% of rural women are allowed to go alone to a health facility. However, the situation seems to improve with age, education and employment status, especially with employment for pay. All this indicates that there is a need for economic and educational empowerment of women in order to improve their basic access to health care (Nayak & Mahanta, 2008).

Women also have reduced access to health care in terms of ability to pay. Table III shows that medical expenditure for both hospitalization and non-hospitalization is much lower for women. It also shows that rural women face more disparity (compared to urban women) in non-hospitalized treatments. Yet, urban women face more disparity in hospitalized treatments (NSS, 2004).

In a study undertaken to investigate urban variations in health service access, women’s visits to health services for prenatal check-ups were compared. The analysis showed that the wealthiest 20% of the population received about 25% of the actual government health spending while the poorest 20% received only 15% (Urban Poverty, 2009).

The health accessibility is affected not only by wealth but also by other socio-economic factors such as sex, race, ethnic group, language, educational level, occupation and residence. Poor women live in
unhealthy environments which have serious implications for their health. Also, they need more money to spend on health care (Kitts & Roberts, 1996).

Table III. Gender Dimensions of Medical Expenditure in India

<table>
<thead>
<tr>
<th>Gender</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>275</td>
<td>322</td>
</tr>
<tr>
<td>Female</td>
<td>240</td>
<td>291</td>
</tr>
<tr>
<td>Person</td>
<td>257</td>
<td>306</td>
</tr>
<tr>
<td>Female as % of Male</td>
<td>87.27</td>
<td>90.37</td>
</tr>
</tbody>
</table>

Average Medical Expenditures (Rupees) per Hospital

<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5946</td>
<td>3778</td>
<td>Male</td>
<td>9535</td>
<td>4185</td>
</tr>
<tr>
<td>Female</td>
<td>5406</td>
<td>2510</td>
<td>Female</td>
<td>8112</td>
<td>3625</td>
</tr>
<tr>
<td>Person</td>
<td>5695</td>
<td>3202</td>
<td>Person</td>
<td>8851</td>
<td>3921</td>
</tr>
<tr>
<td>Female as % Male</td>
<td>90.92</td>
<td>66.44</td>
<td>Female as % Male</td>
<td>85.08</td>
<td>86.62</td>
</tr>
</tbody>
</table>


The above factors negatively influence the health status of Indian women. Poor health has repercussions not only for women, but also for their families, especially for their young children. Women in poor health give birth to low-weight infants. Women in poor health are also unable to provide adequate food and adequate care to their children. Women’s poor health may also affect her household’s economic condition. She would be less productive if she works for pay.

Socio-Cultural & Political Determinants

Most women do not have autonomy in decision making in their personal lives. At the macro level, women are also under-represented in governance and other decision-making positions. In Madhya Pradesh and Rajasthan, less than 50% of women have any access to money in the household (IIPS & ORC Macro, 2000). Parents also discriminate against their female children through neglect during illness. When sick, little girls are not taken to the doctor as often as their brothers are. A study in Punjab showed that medical expenditures for boys are 2.3 times higher than for girls (Coonrod, 1998).

M.A. Wahab of Southern Health Improvement Society (SHIS) which is working in woman’s health in West Bengal, states that “despite
the presence of awareness and facilities, the Indian urban woman is locked in the vortex of work-life struggle.” He further says, “… she lacks a peer group to motivate her to go for regular checkups and stop lifestyle ailments? at its onsets. Trapped in the mesh of her own loneliness the urban Indian woman often reaches to a point of no return as far as her health is concerned” (Biswas, 2010).

POLICY SUGGESTIONS

According to Sally Thorne, “what counts as knowledge is being re-defined in terms of capacity to influence policy” (Thorne, 2001). Therefore, the need to generate such knowledge as would bring a change in the way policies are formulated.

Economic growth needs to be followed with progress on family health and female education, to achieve the millennium development goals (MDGs) by 2015. In order to ensure that public money is spent properly, civil society groups and local communities will be required to play a larger and a more meaningful role. The following are some policy suggestions to improve the health status of urban Indian women:

Empowerment Measures: The Colombo Call for Action (WHO, 2009), acknowledged some steps taken by individual countries such as the contributory social security system for self-employed women in India. Contributing to the empowerment of individuals, in particular women and vulnerable groups, the following were suggested: employment generation, giving access to finances and skill improvement, improvements in societal conditions, scaling-up country specific innovations that successfully address health inequities through a social-determinants approach, sharing lessons across countries in the region, and establishment of national institutional mechanisms to coordinate and manage inter-sectoral action for health in order to mainstream health equity in all policies, and where appropriate, using health and health equity impact assessment tools (WHO, 2009).

The need to put more vigor into programs like the one started with the assistance of UNICEF, a centrally sponsored program of Urban Basic Services, was introduced in 1986, to provide basic social services and physical amenities in urban slums. It was started with a view to bring together health, education, social welfare and industry/industrial training in urban slums, while focusing on child and women’s survival and development through immunization, nutrition supplementation, provision of preschool and crèche facilities and training for income generation in relation to social services. It also aimed at the provision of basic physical facilities such as water supply, drainage and low cost sanitation in relation to physical services. The program emphasized
community based management through neighborhood committees of the urban poor themselves (UNICEF, 1993).

*Improving Living Conditions:* A scheme called Environmental Improvement of Urban Slums (EIUS) aims at ameliorating the living conditions of urban slum dwellers and envisions provision of drinking water, drainage, community baths, community latrines, widening and paving of existing lanes, street lighting and other community facilities (Urban Poverty Alleviation Programs, 1993-1994).

Other issues that need focus are related to at least two broad areas. First, improving the access and availability of basic amenities and public provisioning related to water, fuel, toilets and sanitation, electricity and so on, in order to improve the conditions of living and well-being of poor women. Second, addressing factors involving external environment such as shelter spaces, transport, overall security levels that can improve the standards of living for poor women. Also, facilitation of their participation in the urban labour market is recommended (Rustagi Sarkar & Joddar, 2009).

It has been suggested that 2-3% of the GDP be allocated towards health services, and essential drugs be made available free of charge, through a strong, accountable and sensitive health-care system. There is a need to specify clear indicators in order to monitor the health system.

*Popularizing Regular Medical Checkups:* Regular and thorough medical check-ups of urban women need to be popularized through awareness campaigns. Working women should be given off-time, without sacrificing their pay, for regularly consulting their doctors regarding their health. Lifestyle coaching for women in schools, colleges, work places, and at community meetings need to be organized to create health consciousness at all levels.

*Cluster Services & Child Care Centers:* The importance of creating an enabling environment for women and children to benefit from products and services disseminated under the reproductive and child health programs should be realized. This can be achieved by creating cluster services for women and children at the same place and time. This will promote positive interactions in health benefits and may reduce service delivery costs (Tinker, Finn & Epp, 2000).

It has been suggested that more child care centers be opened in urban slums, where women workers can leave their children in a safe environment. Access to child care can also stimulate female participation in paid employment, help reduce school drop-out rates of girls who serve as baby-sitters, and promote school enrolment as well. The anganwadis (the government run crèche at community level) in India are
a partial solution, but the quality of their operations needs to be enhanced and standardized. Also, making quality maternal and child health services accessible to all women through cluster services for women and children at the same place and time is crucial. Services that can be clustered are prenatal and post-partum care, monitoring infant growth, availability of contraceptives and medicine kits, and routine immunizations. Life-saving skills training of birth attendants and community midwives at district-level hospitals as well as management of asphyxia and hypothermia are important. Also needed is the integrated management of childhood illnesses for infants (National Population Policy, 2000).

Elimination of Gender Disparities: Utmost importance must be given to the elimination of gender-related health inequities in order to balance the social determinants of health. Improvement of health information systems and building research capacity in order to monitor and measure the health of national populations are also crucial. Work needs to progress regardless of age, gender, ethnicity, race, caste, occupation, education, income and employment, where national laws and context permit (WHO, 2009).

The experience of states where the total fertility rate of 2.1 has been achieved, has demonstrated that different approaches have to be adopted in different situations. Goa, the first administrative unit to achieve the replacement level of fertility, achieved it with high literacy and good health care infrastructure. In Kerala, the first state to achieve replacement level of fertility, the factors that helped were high status of women, female literacy, later ages at marriage and low infant mortality. Tamil Nadu which was the second state to achieve replacement level of fertility did so because of the strong social and political commitment, backed by good administrative support and availability of family welfare services. Andhra Pradesh could achieve replacement level of fertility, in spite of relatively lower age at marriage and low literacy (Singh, 2003).

The system of medical education needs to sensitize the students to expecting gender variance in their practice of medicine in various disciplines like surgery, pediatrics, gynecology, psychiatry, etc. This recommendation needs to be incorporated at all levels of the policy and implementation mechanisms (Krasnoff, 2000).

Bringing Convergence: Bringing convergence, strengthening, and universalization of the nutritional program of the Department of Family Welfare and the Integrated Child Development Services (ICDS) run by the Department of Women and Child Development, needs proper references is necessary. Also, ensuring training and timely supply of
food and medicines, including STD/RTI(Sexually Transmitted Diseases/ Reproductory Tract Infections) and HIV/AIDS prevention, screening and management in maternal and child health services are needed services. Other important services include the provision of quality care in family planning, including information, increased contraceptive choices and methods, increased access to quality and affordable contraceptive supplies and services at diverse delivery points, counseling about the safety, efficacy and possible side effects of each method, and appropriate follow-up. Developing a health package for adolescents is also important (Mishra, 2000).

Access to Safe & Legal Abortions: In affluent states where dissemination of both contraceptive information and contraceptives has been established, abortion becomes a rarely utilized final option in terminating unwanted pregnancies. However, and unfortunately, in the developing regions of the world, abortion is still a frequently utilized form of birth control. So, there remains a need for making safe and legal abortion services available to women and household decision makers by 1) increasing geographic spread; 2) enhancing affordability; 3) ensuring confidentiality; and 4) providing compassionate abortion care, including post-abortion counseling. Modifying the syllabus and curricula for medical graduates in these matters is necessary, as well as enhancing continuing education in newer procedures (Kapilashrami et al., 2004). Developing maternity hospitals at sub-district levels and at community health centers to function as ‘first referral units’ for complicated and life-threatening deliveries will reduce additional risks for women (National Population Policy, 2000).

Redefining Standards: It is important to formulate and enforce standards for clinical services in the public, private, and NGO sectors. Focus on distribution of non-clinical methods of contraception (condoms and oral contraceptive pills) through free supply, social marketing as well as commercial sales must be given priority (National Population Policy, 2001).

Multi Pronged Strategy: A multi-pronged strategy to improve the health of Indian women is needed. Inspiration can be drawn from Tamil Nadu where policies such as free education for girls and other forms of government support have helped the state to achieve one of the healthiest sex ratios in the country. The ‘Ladli’ scheme of the Delhi government, which provides financial support to girls of poor families, is another positive move. Efforts should also be made to rope in community leaders. The role being played by Gurudwaras (place of worship in the Sikh religion) in Punjab in campaigning against female
foeticide is a good example. Economic empowerment of women combined with cultural and community initiatives are the answer to society’s alarming gender skew (Times of India, 2010).

The Sarva Shiksha Abhiyan programme for universalisation of primary education and the Mahila Samakhya programme which has set up alternative learning centres for teaching empowering skills to girls from disadvantaged communities, are among the major initiatives of the Indian government to improve literacy levels (UNICEF, 2007).

Networking: The National Population Policy, 2000, suggested, “create a national network consisting of public, private and NGO centers, identified by a common logo, for delivering reproductive and child health services free to any client. The provider will be compensated for the service provided, on the basis of a coupon, duly counter-signed by the beneficiary, and paid for by a system to be devised. The compensation will be identical to providers across all sectors. The end-user will choose the provider of the service. A group of management experts will devise checks and balances to prevent misuse” (India-National Population Policy, 2000). States should incorporate initiatives for urban health needs in their program/implementation plans. The WHO, the Indian government and health/municipal authorities, women’s organizations, the NGOs, and the community groups need to work in tandem. More importantly, men and women need to become aware of the equality of sexes and need to respect the same. Both sexes need to learn how to live in co-operation and harmony, which is often difficult to secure in traditionally very patriarchal parts of the world.

REFERENCES


http://www.usaid.gov/in/our_work/health/index.html, 
(Retrieved October, 2010)

Health (2010). 

Washington, DC.


