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WOMEN'S HEALTH IN INDIA

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Abstract—*In every society the women community was not given due attention especially on the health aspect. In most societies, women are the most deprived sections from all the health facilities. They are the most affected groups right from conception to the end of their lives in terms of poor medical care during pregnancy, after delivery as a baby, as a girl, and as a woman. The extent of empowerment of women in the national hierarchy is determined largely by the three factors her economic, social and political identity and their weightage. These factors are deeply intertwined and interlinked with many cross cutting linkages which imply that if efforts in even one dimension remain absent or weak, outcomes and momentum generated by the other components cannot be sustained as they will not be able to weather any changes or upheavals. It is only when all the three factors are simultaneously addressed and made compatible with each other than the woman can be truly empowered. They suffer from poor nourishment, medical care, education and moral support. Women's health involves their emotional, social and physical well-being. If health is defined 'as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', it follows that existence is a necessary condition for aspiring for health. The girl child in India is increasingly under threat. In recent decades, there has been an alarming decrease in the child sex ratio (0-4 years) in the country. Health is concerned with qualitative improvement and it is not subject to exact measurement. The prevalent indices to measure health status are Death Rate, Infant Mortality Rate, incidence and prevalence of diseases, admission rates of patients to the hospitals, expectation of life and so on. Among these, mortality and life expectancy is the widely used measure of health status of a population. Morbidity may be a more useful indicator than mortality because it is related to pain and sufferings of the people while mortality is a terminal event (Chen, 1990). Healthy lifestyle and high intake of nutritious food can provide good health throughout life to the humans. The poor nutrition and unawareness on the utilization of health facilities during their childhood and reproductive age are the major factors responsible for the high maternal mortality. Though government of India has been taking several efforts to improve the health status of the women, poverty, gender discrimination and illiteracy in the population are the major problems associated with the implementation of appropriate interventions.*

The present overview focuses the major factors, which influence the health concerns of the women in India. Therefore for holistic empowerment of the woman to happen social, economic and political aspects impacting a woman's life must converge effectively. In this paper based on secondary information, an attempt is made to examine the health status of women in India.

1. Introduction.

Women's health concern is influenced by interrelated biological, social, and cultural factors (Figure 1). The approach to women's health has evolved over the 90s from a target-oriented approach into a more holistic, integrated lifecycle and needs-based approach. The challenge is to ensure that women's health throughout the life cycle, from birth to old age, is a public health priority; and that it is viewed in a holistic manner that encompasses decline in the incidence of diseases; improvement in access to, and the quality of services; and empowers women to make informed choices. Improvement in the health status of women is sought to be achieved through access and utilisation of health, family welfare and nutrition services with special focus on the underprivileged segment. The Government of India is engaged in considering ways and means of fostering active community involvement in the population and reproductive health programme. Bringing down the incidence of maternal mortality is a priority. The progress is evident from the data, which shows fall in maternal mortality rate (MMR) from 437 in 1993 to 407 in 1998. The total fertility rate (TFR) stood at 3.2 in 1998 and the objective is to bring this down to 2.1 by 2010. Infant mortality rate (IMR) for girls was 70.8 in 1999 and 69.8 for boys. Latest data suggests that the IMR in 2002 stood at 65 for girls and 62 for boys. The crude birth rate fell from 29.5 to 25.0 and the crude death rate from 9.8 to 8.1 between 1991 and 2002 respectively. Maternal mortality, despite the fall in the MMR, remains high. In Uttar Pradesh and Rajasthan, it is 707 and 670 respectively. Other states in which MMR is above the national average of 407 are Madhya Pradesh, Bihar and Assam. Causes of maternal death include hemorrhage, sepsis, obstructed/ prolonged labour, unsafe abortion, anemia, etc. Factors responsible include poor health care facilities, lack of access to health care units, poor nutrition, early marriage, frequent and closely spaced pregnancies. Access of the poor to integrated health services is limited, especially in rural areas, despite the fact that the poor face a disproportionate disease burden. The resurgence of communicable diseases is a challenge. The Common Minimum Programme of the present government commits to increase public health expenditure to 2–3% of GDP. The government proposes to launch a National Rural Healthcare Mission throughout the country to improve healthcare delivery

over the next five years. Key measures include a national scheme for health insurance for poor families, special attention to poorer sections, food and nutrition security, focused population stabilization programme in high fertility districts, replication of success of the southern states, and availability of life saving drugs at reasonable prices. Profound studies reported that women are more sickly and disabled than men throughout the life cycle. It has been suggested that women are particularly vulnerable, where basic maternity care is unavailable. Due to the involvement of biological factors, women are more prone to sexual exposure of contracting sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV) than do men. Moreover an early marriage and childbirth could be responsible for the prevailing wide variation in the socioeconomic status. Profound studies pointed out the voluntary involvement of the community paramedical workers, NGO, policy makers and teachers in various developmental programs for the removal of poverty and improve the literacy rate among females. Nutrition and health education should be strengthened via department of health to improve the nutritional status of mother and child, which are intimately linked. A strong and sustained government commitment is therefore needed to improve women's health concern.

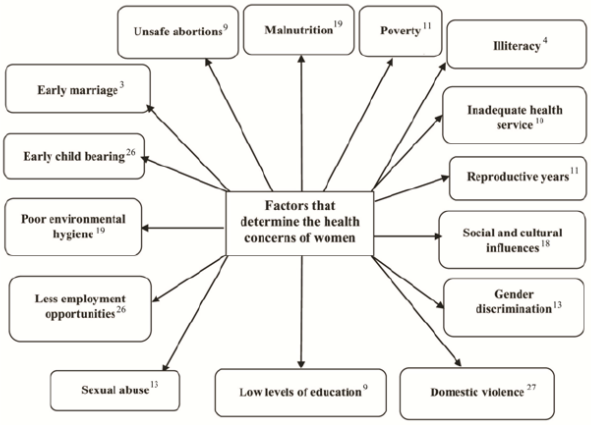


Fig: 1 Factors that determine the health concerns of the women.

1. HISTORY.

Every year, 99% of maternal deaths occur in developing countries. Despite the increase in contraceptive use over the past 30 years, significant unmet needs remain in all regions. Every day, approximately 1000 women die due to complications of pregnancy and childbirth nearly all of these deaths are preventable. Access to family planning is also known to play an important role in reducing maternal mortality. Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services. According to WHO, improving access, coverage and quality of services depends on the key resources being available; on the ways services are organized and managed, and on incentives influencing providers and users. This paper highlights some of the basic issues of the women community in India and their remedies. The scientific community and the public have become increasingly aware of and justifiably concerned about the health of women and there is consequent increasing demand to evaluate the potential health risk factors of the women community. Health doesn't mean body/physical fitness it is actually over all wellbeing which includes mental and social fitness too that can be represented by health triangle (Fig 2) thus we can define health as "the measure of our body's efficiency and overall wellbeing". and reproductive years. On the other hand on preference along with highly dowry costs for daughters, sometimes results in the mistreatment of daughters aggravate the problem, and because of this daughters are neglected for the health care facilities most of the times. It is a fact that most of the women are getting married before leaving the schools/ colleges in our country (Fig 3) and most women in rural areas are not aware of the different types of diseases (Fig 4).

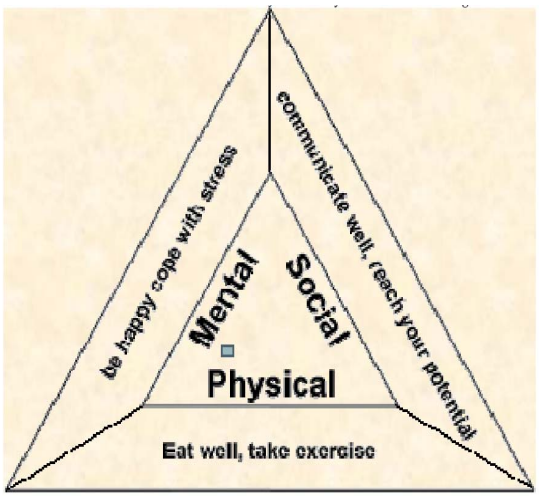
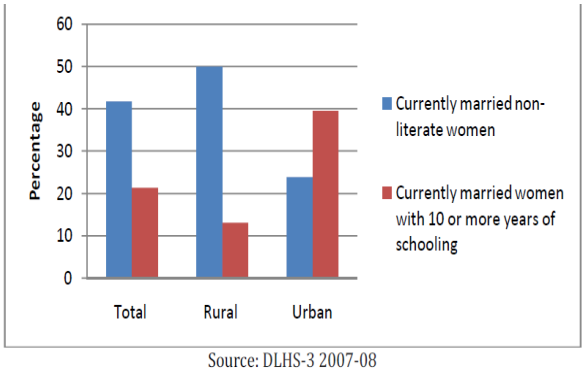


Fig: 2 Health triangle



Source: DLHS-3 2007-08

Fig: 3 Percentage of characteristics of woman.

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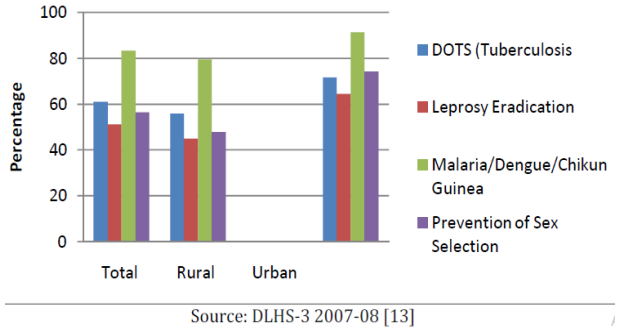
India a traditional country, where women are respected as Matrishakti. Health care access is important for women as women's body changes throughout her life time, from fetal development to post menopause. They use medical services more often than men, especially during their reproductive years. Many women also face huge social, economic and cultured barriers to having lifelong good health. Several reasons have been found to cause health problems all over the country. There is a strong correlation between illiteracy and women's health. It has been found that children of illiterate mothers are twice undernourished as compared to the children of literate mothers. The educational level and place of residence has direct role in morbidity and mortality of women folk. Almost two-thirds (70%) of all illiterate women received no care compared with 15% of literate women. Women in rural areas were much less likely to receive ANC than women in urban areas (43% and 74%, respectively). Research has shown that numerous women in most parts of India have closely spaced births that also increase the health risk for the mothers. Some argue that the high levels of maternity mortality could be prevented if women had adequate health services as in India the leading contributor to high maternal mortality ratios is lack of access to health care.

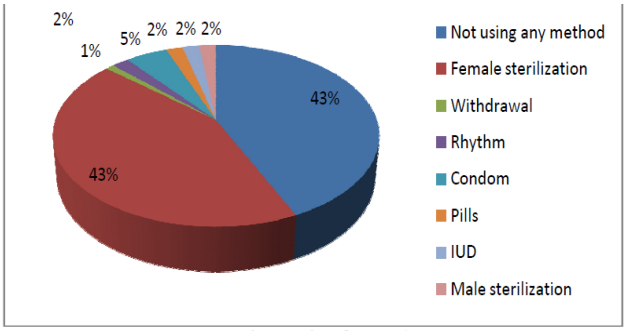


Source: DLHS-3 2007-08 [13]

Fig: 4 Percentage of awareness about the government Health Programmes.

From a global perspective, India accounts for 19% of all live births and 27% of all maternal deaths. Even today India's maternal mortality rates in rural areas are India has 16% of the world's population and its 70% of the population resides in rural areas and males significantly outnumber females, an imbalance that has increased over time. There are systematic problems in women's health care as the typical female advantage in life expectancy is not seen in India. India is one of the few countries where women and men have nearly the same life expectancy at birth; however, women's health is a systematic problem because of high mortality rates during childhood among the world's highest. From a global perspective, India accounts for 19% of all live births and 27% of all maternal deaths.

Although violence against women is a health problem, ignored by authorities as it is beyond their perception and sometimes women beating by husband is perceived as a right of husband. The data of crime against women is increasing but the fact is that most of the crimes go unreported. About 1% dowry death for every 100,000 women is reported every year in our country. It has been found that most of the women are not using any kind of contraceptive device in order to prevent sexually transmitted diseases and more often women's are being sterilized in our country other than males (Fig 5).



Source: (NFHS-3), India, 2005-06:

Fig 5.What contraceptive methods do women use

But the realities of women's lives remain invisible and this invisibility persists at all levels beginning with the family to the nation. Although efforts have been taken to improve the status of women, but the constitution dream of gender equality is miles away from becoming a reality, even today. The attention needs to be focused on the following issues to maintain the dignity and respect for women's health in our country. Physical health deals with ability to function and it can be gained and maintained by regular exercise, as it helps to give more energy, keep muscles fit & strong. Balance diet which create a balance between what we eat and the way our body uses the food for energy and growth, another factor which is essential for physical health is sufficient sleep as daily 6-8 hour sleep is must for healthy mind. Regularity in sleep time is also one of the factor otherwise biological clocks of body get disturbed.

2. Concern for the women of INDIA.

The below categories of women find themselves more vulnerable on account of their unique social, cultural circumstances or because they are victims of violence or abuse.

The Critical areas of concern for the women of INDIA are as follows

2.1. Trafficked victims,
2.2. Women who are labeled as witches,
2.3. Acid attacked,
2.4. Women impacted by internal displacement, disasters and Migration,
2.5. Either for economic reasons,
2.6. Conflict e.g. refugee women,
2.7. Women who have been displaced because of SEZ, building of dams etc,

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2.8. Women impacted by natural or man-made disasters,
2.9. Women and Labour,
2.10. Domestic labour,
2.11. Bonded labour,
2.12. Destitute women who are homeless,
2.13. Women in Agriculture,
2.14. Land less women,
2.15. Marginal farmers,
2.16. Agricultural workers,
2.17. Women and Health,
2.18. Women affected by HIV/ AIDS,
2.19. Women suffering from life threatening diseases,
2.20. Women with disabilities,
2.21. Elderly and aged women,
2.22. Slum Dwellers,
2.23. Women Prisoners,
2.24. Women belonging to ethnic and socially vulnerable communities,
2.25. Women belonging to ethnic and religious minorities (especially Muslims),
2.26. Women belonging to socially backward communities (SC, ST),
2.27. Single women,
2.28. Adolescents,
2.29. Widows,
2.30. Women whose husbands are absent due to conflict, economic migration etc,
2.31. Divorcees,
2.32. Women and Poverty,
2.33. Education and training of women,
2.34. Women and health,
2.35. Violence against women,
2.36. Women in armed conflict,
2.37. Women and economy,
2.38. Women in power and decision-making,
2.39. Institutional mechanisms for the advancement of women,
2.40. Human rights and women,
2.41. Women and media,
2.42. Women and environment,
2.43. Girl child.
2.44. Women Impacted by Violence domestic, and
2.45. Rape

The possibility of developing pilot projects suitably formulated to address specific requirements may be examined.

3. Constitutional provisions.

Women as an independent group constitute 48% of the country's total population as per the 2001 Census. The importance of women as a important human resource was recognized by the Constitution of India which not only accorded equality to women but also empowered the State to adopt measures of positive discrimination in their favour. A number of Articles of the Constitution specially reiterated the commitment of the constitution towards the socio economic development of women and upholding their political right and participation in decision making. Drawing the strength from the constitutional commitments, the Government of India has been engaged in the continuous endeavor of concretely translating all the rights, commitments and safe guards incorporated in the Indian Constitution for women.

3.1. **The different Articles, Acts, Amendments are as follows.**

4.1.1. Article 14: Men and women to have equal rights and opportunities in the political, economic and social spheres.
4.1.2. Article 15(1): Prohibits discrimination against any citizen on the grounds of religion, race, caste, sex etc.
4.1.3. Article 15(3):Special provision enabling the State to make affirmative discriminations in favour of women.
4.1.4. Article 16:Equality of opportunities in matter of public appointments for all citizens.
4.1.5. Article 39(a):The State shall direct its policy towards securing all citizens men and women, equally, the right to means of livelihood.
4.1.6. Article 39(d):Equal pay for equal work for both men and women.
4.1.7. Article 42:The State to make provision for ensuring just and humane conditions of work and maternity relief.
Article 51 (A)(e):To renounce the practices derogatory to the dignity of women.

3.2. **Equal Remuneration Act of 1976** provides for equal pay to men and women for equal work.
3.3. **Hindu Marriage Act of 1955** amended in 1976 provides the right for girls to repudiate a child marriage before attaining maturity whether the marriage has been consummated or not.
3.4. **The Marriage (Amendment) Act, 2001** amended the Hindu Marriage Act, Special Marriage Act, Parsi Marriage and Divorce Act, the Code of Criminal Procedure providing for speedy disposal of applications for maintenance; the ceiling limit for claiming maintenance has been deleted and a wide discretion has been given to the Magistrate to award appropriate maintenance.
3.5. **The Immoral Traffic (Prevention) Act** of 1956 as amended and renamed in 1986 makes the sexual exploitation of male or female, a cognizable offence. It is being amended to decriminalize the prostitutes and make the laws more stringent against traffickers.
3.6. An amendment brought in 1984 to the **Dowry Prohibition Act of 1961** made women's subjection to cruelty a cognizable offence. The second amendment brought in 1986 makes the husband or in-laws punishable, if a woman commits suicide within 7 years of her marriage and it has been proved that she has been subjected to cruelty. Also a new criminal offence of 'Dowry Death' has been incorporated in the Indian Penal Code.

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3.7. **Child Marriage Restraint Act of 1976** raises the age for marriage of a girl to 18 years from 15 years and that of a boy to 21 years and makes offences under this Act cognizable.

3.8. **Medical Termination Pregnancy Act of 1971** legalizes abortion by qualified professional on humanitarian or medical grounds. The maximum punishment may go upto life imprisonment. The Act has further been amended specifying the place and persons authorized to perform abortion and provide for penal actions against the unauthorized persons performing abortions.

3.9. **Indecent Representation of Women (Prohibition) Act of 1986 and the Commission of Sati (Prevention) Act, 1987** have been enacted to protect the dignity of women and prevent violence against them as well as their exploitation.

3.10. **The Protection of Women from Domestic Violence Act, 2005** provides for more effective protection of the rights of women guaranteed under the Constitution who are victims of violence of any kind occurring within the family and for matters connected therewith or incidental thereto. It provides for immediate and emergent relief to women in situations of violence of any kind in the home.

4.11. Legislations and laws for women.

The State enacted several women-specific and women-related legislations to protect women against social discrimination, violence and atrocities and also to prevent social evils like child marriages, dowry, rape, practice of Sati etc. The recently notified Prevention of Domestic Violence Act is a landmark law in acting as a deterrent as well as providing legal recourse to the women who are victims of any form of domestic violence. Apart from these, there are a number of laws which may not be gender specific but still have ramifications on women.

4.11.1 The objectives of all the Policy include.

4.11.1.1. Creating an environment through positive economic and social policies for full development of women to enable them to realize their full potential,

4.11.1.2. The *de-jure* and *de-facto* enjoyment of all human rights and fundamental freedom by women on equal basis with men in all spheres – political, economic, social, cultural and civil**,**

4.11.1.3. Equal access to participation and decision making of women in social, political and economic life of the nation**,**

4.11.1.4. Equal access to women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office etc,

4.11.1.5. Strengthening legal systems aimed at elimination of all forms of discrimination against women**,**

4.11.1.6. Changing societal attitudes and community practices by active participation and involvement of both men and women,

4.11.1.7. Mainstreaming a gender perspective in the development process,

4.11.1.8. Elimination of discrimination and all forms of violence against women and the girl child, and

4.11.1.9. Building and strengthening partnerships with civil society, particularly women's organizations.

4.12. Commitments in the NCMP for Women.

4.12.1. Introduce legislation for one-third reservations for women in Vidhan Sabhas and in the Lok Sabha,

4.12.2. Legislation on domestic violence and against gender discrimination will be enacted,

4.12.3. At least one-third of all funds flowing into panchayats will be earmarked for programmes for the development of women and children,

4.12.4. Village women and their associations will be encouraged to assume responsibility for all development schemes relating to drinking water, sanitation, primary education, health and nutrition,

4.12.5. Complete legal equality for women in all spheres will be made a practical reality, especially by removing discriminatory legislation and by enacting new legislation that gives women, for instance, equal rights of ownership of assets like houses and land.

5. Prevalence of gender based violence.

Violence against women (VAW) includes any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Violence against women manifests itself in many ways and is one of the most pervasive forms of human rights abuse in the world today. While all women may experience violence, it intersects with other social and identity-based constructs like caste, religion, ethnicity, disability, and sexual orientation to make specific groups vulnerable to different and particular forms of violence. Thus, the nature of the violence and how it manifests itself may differ because of social location. To effectively deal with the problem of violence against women efforts are being made to strengthen the existing legislation through review and amendments and develop institutional mechanisms. The Support Services, in place, to victims of violence are Short Stay Homes, Swadhar , Help lines for women in distress, Legal Literacy and Legal Awareness Camps, earmarking of one Fast Track Court in a district, (where there are two) to deal exclusively with cases of violence against women, constitution of the National Commission for Women (NCW) and State Commissions, increased recruitment of women police officers, establishment of women police cells in police stations and exclusive women police stations and establishment of Rape Crisis Intervention Centres in police districts in some big cities. In addition to these, efforts are being made to sensitize judiciary, police and civil administration. Despite these efforts, crimes against women in the country continue to be on the increase. As per the latest

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data published by the National Crime Records Bureau, the total number of crimes committed against women has been increasing from year to year from 1.31 lakhs in 1998, 1.36 lakhs in 1999, 1.44 lakhs in 2001 and 1.51 lakhs cases in 2005, consisting of offences such as torture, molestation, rape, abduction, sexual harassment, dowry deaths, immoral traffic and others. During 2004 the incidence of torture and molestations have accounted for 37.7% and 22.4% respectively, of the total crimes against women, followed by cases of rape, kidnapping, abduction to the extent of 11.8% and 10.1%. 2.9% of the rape victims were less than 10 years of age. The number would be larger as most cases go unreported due to social stigma attached to it. In 2004, 19.7% rape cases have been tried in the courts out of the total of 71,620 cases for trial and in only 25.2% of cases conviction was made. The crime clock maintained by the NCRB reveals a shocking figure of:

5.1. 1 Crime Committed Against Women every 3 Minutes,
5.2. 1 Molestation case every 15 Minutes,
5.3. 1 Rape case every 29 Minutes,
5.4. 1 Sexual Harassment case every 53 Minutes,
5.5. 1 Dowry Death case every 77 Minutes, and
5.6. 1 Cruelty by Husband and Relatives case every 9 Minutes.

The Tenth Five Year Plan addressed the problems of violence against women on top priority basis through a well-planned Programme of action, with both short and long term measures, both at the national and state levels. Amendments were recommended in the Indian Penal Code and other related legislations to make punishment more stringent. Collaborative interventions in the Tenth Plan with the NGOs helped to bring about societal orientation, an important area to deal with the problem of different forms of violence against women in society. The Mid Term Appraisal to the Tenth Plan also identified violence against women as one of the burning issues affecting women. The problem of VAW has to be dealt with holistically. Draft Approach Paper for the 11th Five Year Plan has included Violence against Women as one of the three aspects relating to the problems of women in the country, the other two being Economic Empowerment of Women and Women's Health. Thus a major challenge before the XI Plan is to enable the creation of an environment for women that is safe and free from violence. Only then it would be possible for women to be true partners in India's democracy at the social, economic and political level. Forms of violence that take place at the community include witch hunting, sati, child marriage, and incidents of public stripping. These unfortunately are increasing in prevalence. In recent years there have been disturbing reports of cases of sati and its subsequent glorification. There has been an alarming rise in reported cases of honor crimes committed in the name of protecting family or community honor. Equally worrying is the growing numbers of anti-women strictures being pronounced by community-based structures like caste and religious panchayats. The brunt of these so called judgments, which in some cases have resulted in brutal punishments, such as dismemberment and mutilation, are usually borne by women or the women's family. Many such actions follow when women try and change age old, narrow and regressive social norms, like marrying outside one's caste or religion. Many of these so-called judgments are not only anti-women but go against the Constitution. Experiences from the ground and various reports are now showing that women are specifically targeted in situations of communal and sectarian violence as they embody the so-called honor of the community. If a particular community or group is to be attacked and humiliated, women are targeted. In such situations women are victims of various forms of sexual violence including rape, molestation, mutilation, stripping etc. In areas experiencing tension and conflict like the North- East and Kashmir women are particularly vulnerable and are caught in the crossfire. There have been reports of sexual violence perpetrated by security forces as well. Many women in such situations experience trauma.

6. Status of women a situational analysis.

Though the Constitutional commitments of the nation to women was translated through the planning process , legislation , policies and programs over the last six decades yet as the Eleventh plan approaches, a situational analysis of social and economic status of women reflects less than satisfactory achievements in almost all important human development indicators. The maternal mortality rate is estimated at 407 per 100,000 live births (2000) in India compared to figures of 92 in Sri Lanka, 56 in China and 130 in Vietnam; the growing female face of HIV/AIDS is reflected in the fact that the number of pregnant women (between 18-24 years) with HIV prevalence comprise 0.86 % in 2003 of the total women pregnant compared to 0.74% in 2002. The saga of missing daughters is vividly depicted in the growing incidence of female feticide as a result of which the child sex ratio has declined from 945 in 1991 to 927 in 2001. While the literacy rates have shown an improvement from 39.3% to 54.3% of the total female population between 1991 and 2001, yet much more needs to be done especially for socially and economically backward regions and groups. Economic empowerment as reflected by the work participation rate shows that the percentage of women in the work force increased by only 3% (from 22.5% to 25.7%) between 1991 and 2001. The average wage differential between men and women showed a marked deterioration between 2000 and 2004 for both rural and urban areas. The violence against women continued unabated with the absolute number of crimes against women increasing from 1, 28,320 in 2000 to 1, 43,615 in 2004. There are a number of generic reasons, which give rise to the dismal picture depicted above. Poverty is increasingly becoming femininsed mainly on account of the fact that with globalization and liberalization, a paradigm shift in the country's economy has taken place skewed towards technology dominated sectors, rendering traditional sectors

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like agriculture unviable and without any security cover. Unfortunately Expectation of life at birth for 1994-1998 62.2 female in years 1998-2002 63.3 1991 39.3 Literacy rate for female (in %) 2001 54.2 Maternal Mortality Rate per 1991 437 1,00,000 live births 1998 407 Sex Ratio 1991 927 2001 933 HIV prevalence among pregnant 2002 0.74 women aged 15-24 years(in %) 2003 0.86 HIV prevalence among pregnant 2002 0.80 women aged 25-49 years (in %) 2003 0.88 Work participation rates for 1991 22.3 female (in %) 2001 25.7 Wage differentials between male 1999-2000 15.83 and female in Rural areas 2004-05 20.38 Wage differentials between male 1999-2000 24.55 and female in Rural areas 2004-05 31.23 Crimes against women (no. in 2000 1.28 lakh) 2004 1.4410 it is in these sectors that women predominately eke out a sustenance livelihood. The lack of alternate employment, skill training, or credit facilities for women who seek it, is another factor that keeps them in poverty. Traditional patriarchal systems too play their part in keeping women at a lower rung in the social and economic hierarchy by denying them basic rights to land, assets etc and also placing a low value on their existence. The high prevalence of female feticide and child marriage is a fall out of these factors.

The weak social infrastructure such as the lack of adequate schools or health centers, drinking water, sanitation and hygiene facilities inhibits a very large section of women from accessing these facilities. This is a major reason why women continue to face problems as poor literacy rates, or health issues. It is also one of the reasons for the high incidence of MMR and IMR. The changing socio economic scenario and the phasing out of the joint family system along with poor community based protection systems are some of the reasons why women are becoming increasingly prone to violence and abuse. The weak law enforcement and gender insensitivity of the various functionaries fail to check the growing violence against women. At the same time, the extremely poor levels of awareness amongst women themselves on their rights also perpetuate violence against them. The lack of adequate rehabilitation and reintegration facilities is another crucial factor that finds victimized women further victimized or ostracized by the community. The media too does not reflect gender issues with sympathy and sensitivity; instead there is a tendency to glorify patriarchal traditions or to depict women as objects of sexual entertainment.

7. Mental health.

It is death with how a person think, feel and cope with their daily life. This can be managed by learning as it increases self-confidence, awareness, knowledge, self-perception and coping skill. Social health deals with the way a person react with people within their environment. Strong and supportive relations with family and friends increase happiness, self-stream and reduce stress. When the three components are balanced than we can say that we are really healthy. Over the last 70 years more than 80,000 chemicals have been released into environment through human activity. Because of inadequate health and safety laws, more than 85% of these chemicals have not been assessed for possible effects on human health. Women's are mainly exposed to indoor pollutants which cause great damage to their health. Women's can expose to these chemicals at home and in work place. They get into body when person breaths, eat, drink, or have skin contact with them. They can be found in household products such as cosmetics and plastic container or can come from industrial pollution and cigarette smoke. The impact of chemicals depends upon time of exposure: Stage of rapid development can be especially time of vulnerable to the effect and exposure at these times can increase risk for health problems later in life. High exposures following accidental or occupational exposure to environment chemicals have shown striking effects and their low doses may also be unsafe. Increasing evidence shows that women's and children are more vulnerable than males to various chemicals There is a close knit knot between mother and child and in the process both get affected. Only few have access to balanced diet that includes plenty of fresh fruits, vegetables, legumes, and whole grains and only few women care to wash fruits and vegetables carefully. Most of the women quite often get olive; instead they regularly get hydrogenated or semisolid fats. The practice of hand washing in most of the rural areas is often neglected by the women folk and transferring their germs from hands to mouth in this process, thus become the victim of various diseases. Most of the women still in India are puffing smoke and making their and their children's life a hell to live in. Rural people in India in general and tribal population in particular, have their own beliefs and practices regarding and cure of diseases. Some tribal groups still believe that a disease is always caused by hostile spirits or by breach of some taboo. The smoky places and smoking habit should be avoided to reduce the burden of respiratory diseases like asthma, bronchitis, emphysema, chest pain. To maintain flexibility women's should exercise regularly, they must walk, swim, jog, dance, garden that may burn their calories and accompany friends that make you happy in order to relieve the stress. Since healthy mind lives in healthy body so a women with good health can contributes better in all fields of life including science and technology.

8. Malnutrition.

Malnutrition, due to deficiencies of calories, protein, vitamins, and minerals and other poor health and social status, affects millions of women and adolescent girls around the world (Figure 2). Malnutrition, a serious health concern, threatens the survival of Indian mothers and their children. Adequate nutrition is thus an essential cornerstone to maintain the healthy health of any individual, especially for women.Baby born to malnourished women faces multiple complications, including cognitive impairments, short stature, lower resistance to infections, and a higher risk of disease and death throughout their lives. Women are more prone to nutritional deficiencies than men due to the fact of women's reproductive biology, low social status, poverty, and lack of education.The two most common nutritional deficiencies in the women

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worldwide are iron deficiency and anaemia. Around 80% of the Indian pregnant women suffer from iron deficiency anaemia's. Nutritional deficiencies, including iron and iodine deficiencies and low intake of essential nutrients could enhance the chances of having a low birth-weight infant, as well as impaired fetal development in pregnant women. Low intake of nutrition during girls' childhood may cause stunted growth, which in turn leads to higher risks of complications during and following childbirth. Mental impairments impede physical development, and harm school performance is the common consequences of iodine deficiency among adolescent girls. Maternal malnutrition often results due to the kind of reproductive cycle, they have and spending more times on household work. Around 450million women are underweight due to protein energy malnutrition during their childhood in developing countries. The highest incidence of malnutrition among women is reported in South Asia. The disorders associated with malnutrition in women are presented in Figure 6.

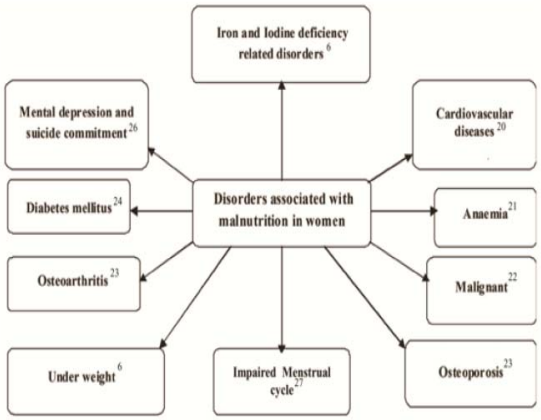

Fig: 6 Disorders associated with malnutrition in women.

9. Tuberculosis.

Tuberculosis has had a worldwide resurgence including in India. It is estimated that about 14 million persons are infected, i.e. 1.55 of total population suffer from radio logically active Tuberculosis. About 1.5 million cases are identified and more than 300000 deaths occur every year Between NFHS 1 and NFHS 2 the prevalence has increased from 4678 per lakh population to 544. Unfortunately, prevalence among working age adults (15-59) is even higher as 675. All these may well be underestimates in so far as patients are traced only through hospital visit. Only about half reach the hospital. Often wrong diagnosis by insufficiently trained doctors or misunderstood protocols is another key problem both public and private sectors. TB is a wide spread disease of poverty among women living and working in ill ventilated places and other undernourished persons in urban slums it is increasingly affecting the younger adults also in the economically productive segments. No universal screening is possible. Sputum positive test does not precede diagnosis but drugs are prescribed on the basis of fever shadows as a result incomplete cure become common and delayed tests only prove the wrong diagnosis too late. Improved diagnosis through better training, clear protocols and elimination of drug resistance through incomplete cure should be priority. Treatment costs in case of drug resistance can soar close to ten times the normal level of Rs. 3000 to 4000/per person treated. Similarly even though the resistant strain may cover only 8% at present, it could suddenly rise and as it approaches 2000 or so, there is a danger that TB may get out of control. The DOTS Programme trying for full compliance after proper diagnosis is settling down but already has some claims of success. More than 3000 laboratories have been set up for diagnosis and about 1.5 lakh workers trained and with total population coverage by 2007 cure rates (already claimed to have doubled) may rise substantially. There is reason to hope that DOTS programs would prove a greater success over time with increased community awareness generation. The key issue is how soon and how well can it be integrated into the PHC system and made subject to routines local accountability, without which no low cost regime of total compliance is feasible. In a country as large as India an optimistic assessment could be that with commitment and full use of infrastructure it will be possible to arrest further growth in absolute numbers of TB case keeping it at below 1.5 million till 2010 even though the population will be growing. Once that is done TB can be brought down less than a million lie within internationally accepted limits and disappears as a major communicable disease in India by 2020.

10. Malaria.

As regards malaria, we have had a long record of success and failure and each intervention has been thwarted by new problems and plagued by recrudescence. At present India has a large manpower fully aware of all aspects of malaria about often low in motivation. It can be transformed into a large-scale work force for awareness generation, tests and distribution of medicine. In spite of past successes, there is evidence of reemergence with focal attacks of malaria with the virulent falciparum variety especially in tribal areas. Priority tribal area malaria stands fully funded by the center. About 2 million cases of malaria are recorded all over India every year with seasonal high incidence local failures of control. Drug resistance in humans and insecticide resistant strains of mosquitoes present a significant problem. But there is a window of opportunity in respect of DDT sensitive areas in eastern India where even now malaria incidence can be brought down by about 50% within a decade and be beneficial for control of Kalaazar and JE. There is growing interest and community awareness of biological methods of control of mosquito growth. Unfortunately diligent ground level public health work is in grave disarray and these areas but can be improved by better supervision greater use of panchayat raj institutions and buildings on modest demonstrated successes. As regards vaccine, there seems to be no sufficient incentive for international R&D to focus on relatively lower priority or

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research. Roll back malaria programmes of the WHO are more likely to concentrate on Africa whose profile of malaria is not similar to ours. The search for a vaccine continues but has little likelihood of immediate success. In spite of various difficulties, if the restructuring of the malaria work force and the strengthening of health infrastructure takes place, one can expect that the incidence can be reduced by a third or even up-to half in the next decade or so. For this it is necessary that routine tasks like timely spraying and logistics for taking blood slides testing and their analysis and organic methods of reducing mosquito spread etc. Are down staged to community level and performed under supervision through panchayats within the community participation, public education and local monitoring. Malaria can certainly be reduced by a third even up-to a half in ten years, and there is a prospect of near freedom from malaria for most of the country by 2020.

11. The case of AIDS.

HIV in India is spreading from high-risk groups to the general population in many areas, and from urban to rural areas. Increasingly the face of HIV/AIDS is female. According to estimates of the National AIDS Control Organisation (NACO) 1 in 3 persons living with HIV in India is a woman. In 2004, it was estimated that 22% of HIV cases in India were homemakers with a single partner. The increasing HIV prevalence among women can consequently be seen in the increase of mother to child transmission of HIV and pediatrics HIV cases. Women are increasingly becoming the face of the HIV epidemic and there are biological, social, legal, cultural, political and economic factors that make them more vulnerable to HIV/AIDS. In turn these factors have an impact on women's access to services, resources, and information. Women have limited ability to negotiate safer sex and the risk and reality of sexual violence also means an increased risk of HIV transmission through unprotected non-consensual sex. In India, testing for the HIV virus is rare until symptoms set in. The numbers suffering from HIV/AIDS are therefore likely to be far higher than estimated. Once HIV/AIDS enters the home, family budgets are reversed forever – often loss of income earning opportunities and expenditure on medical care on the other. Women are the major caregivers in most cases. A multi-sectoral and decentralized, gender sensitive community based health services is needed. The health care systems in the region are inequitably gendered in terms of accessibility, priorities and services provided. As such, effective strategies that address the relationships between gender and HIV/AIDS require a focus on gender within health care in general. There is perhaps an urgent need that the response to the HIV/AIDS epidemic be made multi-sectoral and be integrated into comprehensive, decentralized, participatory community based health services and promote the highest mental and physical health, including empowering women to make decisions related to their sexual and reproductive health. A focus on increasing women's ability to access preventive and treatment and care services is crucial. The success can be built upon till 2025 for reaching levels comparable to China. Concentration on preventive measures of maternal and child health and in particular improved nutrition services will be particularly useful because it will help that generation to have a head start in good health that are going to be a part of the demographic bonus. The bonus is a young adult bulge of about 340 million (with not less than 250 million from rural population and about 100 million born in this century). The bonus will appear in a sequence with South Indian States completing the transition before North Indian States spread it over the next three decades. To ensure best results at this stage the present nutritional services must be converted into targeted (and entitled) benefits of children to help in their growth and not remain as welfare measure. Using the infrastructures fully and with community participation and extensive social mobilization many tasks in nutrition are feasible and can be in position to make impact by 2010.Mild and moderate malnutrition still prevalent in over half of our young population can be halved if food as the to better nutrition becomes a priority both for self-reliance and lower costs. There has been a tendency for micro nutrient supplementation to overwhelm food derived nourishment. This trend is assisted by foreign aid but over a long run may prove unsustainable. By engaging the adolescent into proper nutrition education and reproductive health awareness we can seamlessly weave into the nutritional security system of our country a corps of informed interconnected and imaginative ideas can be tried out. Such social mobilization at low cost can be the best preventive strategy as has been advocated for long by the Nutrition Foundation of India (< Gopalan 2001) and can be a priority in this decade over the next two plan periods.

12. Non communicable diseases and injuries.

Three major such diseases like cancer cardiovascular diseases and renal conditions and neglect in regard to mental health conditions - have of late shown worrisome trends. Cures for cancer are still elusive in spite of palliatives and expensive and long drawn chemo or radio -therapy which often inflict catastrophic costs, In the case of CVD and renal conditions known and tried procedures are available for relief. There is evidence of greater prevalence of cancer even among young adults due to the stress of modem living. In India cancer is a leading cause of death with about 1.5 to 2 million cases at any time to which 7 lac new cases are added every year with 3 lakh deaths. Over 15 lakh patients require facilities for diagnosis and treatment. Studies by WHO show that by 2026 with the expected increase in life expectancy, cancer burden in India will increase to about 14lac cases. CVD cases and Diabetes cases are also increasing with an 8 to 11 %prevalence of the latter due to fast life styles and lack of exercise. Traumas and accidents leading to injuries are offshoots of the same competitive living conditions and urban traffic conditions. Data show one death every minute due to accidents or more than 1800deaths every day in Delhi alone about 150 cases are reported every day from accidents on the road and for every death 8 living patients are added to hospitals due to injuries. There is finally the emerging

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aftermath of insurgencies and militant violence leading to mental illnesses of various types. It is estimated that 10 to 20 persons out of 1000population suffer from severe mental illness and 3 to 5 times more have emotional disorder. While there are some facilities for diagnosis and treatment exist in major cities there is no access whatever in rural areas. It is acknowledged that the only way of handling mental health problems is through including it into the primary health care arrangements implying trained screening and counseling at primary levels for early detection. All these are eminently feasible preventive steps and can be put into practice by 2005 and we should be doing as well or better than China by 2020 considering the greater load of non-communicable diseases they bear now. The burden of non-communicable diseases will be met more and more by private sector specialized hospitals which spring up in urban centers. Facilities in prestigious public centers will also be under strain and they should be redesigned to take advantage of community based approach of awareness, early detection and referral system as in the mode) developed successfully in the Regional Cancer Center Kerala. Public sector institutions are also needed to provide a comparator basis for costs and evaluating technology benefits.' For the less affluent sections prolonged high tech cure will be unaffordable. Therefore public funds should go to promote a routine of proper screening health education and self-care and timely investigations to see that interventions are started in stages I and II.

13. Health Status of Women in India and Kashmir.

India is one of the largest third world countries where females are considered as disadvantaged sections, demographically, socially, culturally and economically. Women are described as the most vulnerable group exposed to various adversities of life. India is one of the few countries where males significantly outnumber females, and the country's maternal mortality rates in rural areas are among the worlds highest. Females experience more episodes of illness than males and are less likely to receive medical treatment before the illness is well advanced. Disease burden per 1000 population in India is much more on women than men. In India, the problems of health hazards are guided by religious beliefs, dogmas and practices. These practices have pervaded the life of an average Indian. In India, it is found that the poor are the worst affected by epidemics and contagious diseases while the upper classes suffer from heart diseases, blood pressure and other sophisticated diseases (Sree Vastava, 1979). The average Indian suffers from protein deficiency, caused by insufficient intake of food, particularly by growing children and lactating mothers. The roots of **t**he poor health situation of the population lie in the neglect of women in the society. Several studies have shown that the neglect of women, from their early childhood, including food and medical attention during illness, and burden of work, has led to poor health and higher death rates among them. Women from their early childhood are trained to accept pain and suffering as part of their lives. This has developed a culture of silence, which has led to women neglecting their health and not taking any treatment if they have health problems. Indifference of the members of the family as well as of the society to the problems of women aggravates the consequence of the neglect (Malini, 1991).

In patriarchal societies, the adverse health outcomes of women are visible at different stages of life cycle. At early child hood, the young children are at high risk of ill health and are more susceptible to death from their illness. In the peak reproductive years, the physical drain of pregnancy and lactation increases women's vulnerability to poor health (Monica, 1987). Kashmir has attained remarkable achievements in social development despite its economic backwardness. Kashmiri women enjoyed relatively high status compared to the women of other states. The high status of women is attributed to the long history of social reforms and importance given to women by reformers, matrilineal system followed by certain sections of population, spread of female education and early inception of family planning and the influence of left movements (Mukhoadhayaya, 2007). Health status of women in India and Kashmir are examined on the basis of indicators such as sex ratio, life expectancy, mortality, age at marriage, reproductive health care, fertility and family planning, nutritional status, morbidity, literacy and education.

14. Life Expectancy.

Generally life expectancy at birth should be high for women compared to men because of the genetic peculiarity of women.

The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. There is a strong son preference in India, as sons are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons. All of these factors exert a negative impact on the health status of Indian women. Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman's health affects the household economic well-being, as a woman in poor health will be less productive in the labor force. While women in India face many serious health concerns, this profile focuses on only five key issues: reproductive health, violence against women, nutritional status, unequal treatment of girls and boys, and HIV/AIDS. Because of the wide variation in cultures, religions, and levels of development among India's 29 states and 9 union territories, it is not surprising that women's health also varies greatly from state to state. To give a more detailed picture, data for the major states will be presented whenever possible. The discrimination against the girl child is systematic

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and for the country. For the country as a whole as well as its rural areas, the infant mortality rate is higher for females in comparison to that for males. Usually, though not exclusively, it is in the northern and western states that the female infant mortality rates are higher, a difference of ten points between the two sexes specific rates not being uncommon. The infant mortality rate is slightly in favour of females in the urban areas of the country (as a whole) But then, urban India is marked by greater access to abortion services and unwanted girl children often get eliminated before birth. It has been commented in the context of women's health that sustainable well-being can be brought about if strategic interventions are made at critical stages. The life cycle approach thus advocates strategic interventions in periods of early childhood, adolescence and pregnancy, with programmes ranging from nutrition supplements to life skills education. Such interventions attempt to break the vicious intergenerational cycle of ill health. The vulnerability of females in India in the crucial periods of childhood, adolescence and childbearing is underscored by the country's sex wise age specific mortality rates. From childhood till the mid-twenties, higher proportions of women than men die in the country. In rural India, higher proportions of women die under thirty. Like most cultures across the world, Indian society has deeply entrenched patriarchal norms and values. Patriarchy manifests itself in both the public and private spheres of women's lives in the country, determining their 'life chances' and resulting in their qualitatively inferior status in the various socio-economic spheres. It permeates institutions and organizations and works in many insidious ways to undermine women's right to dignified lives. There are similarities in women's lived experiences due to such gendered existences. However, in a vast and socio cultural heterogeneous country like India, women's multiple and often special needs are played out on a variegated terrain of age, caste, class and region resulting in a complexity of experiences. Traditional bases of social stratification such as caste and class reproduce themselves in women's lived experiences as also do rural-urban and regional disparities. New needs emerge as women progress through the life cycle. Talking about women's health and access to healthcare in such a complex setup thus poses a challenge.

Health is complex and dependent on a host of factors. The dynamic interplay of social and environmental factors has profound and multifaceted implications on health. Women's lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. But gender identities are played out from various location positions like caste and class. The multiple burdens of 'production and reproduction' borne from a position of disadvantage has telling consequences on women's well-being. The present section on women's health in India systematizes existing evidence on the topic. Different aspects of women's health are thematically presented as a matter of presentation and the themes are not to be construed as mutually exclusive and water tight compartments. The conditions of women's lives shape their health in more ways than one. The population of the world crossed 6 billion in 1999, and India's population crossed 1 billion in 2000. In 2020, India's population is expected to be around billion. Some indicators on the quality of life in Asian countries, including India have improved over the years such as life expectancy, literacy and infant mortality, while others have remained static or deteriorated such as environmental sanitation and environmental degradation. International comparisons on a few of the indicators of human development for Asian countries and indicators for different states in India are given in the tables below.

Table 1: Indicators of Human Development and some Asian Countries.

Indicators of Human Development for SAARC Countries and Some Asian Countries, 2008

Country	Life Expectancy at Birth (years)	Infant Mortality Rate (Per thousand live Births)	Adult Literacy Rate (%) (age 15 years & above)
India	64	54	66
Bangaladesh	64	47	54
Bhutan	66	56	56
China	73	19	93
Indonesia	70	25	91
Malaysia	74	10	92
Maldives	68	26	97
Nepal	64	43	57
Pakistan	65	73	55
Philippines	72	23	93
Srilanka	72	17	92
Thailand	70	6	94

15. Women and Media.

In an age of developing technology and mass media, the portrayal of women in the media has a significant impact on women's rights. Print and audio visual media can be used to create public awareness on women's rights and break patriarchal stereotypes. However, any portrayal that is derogatory to women may have the opposite effect of perpetuating stereotypes. Hence there is need to promote positive images of women in the media while, at the same time, respecting a citizen's right to freedom of expression and right to information. The existing law on regulating content on the media is contained in three different sources. Firstly, Article 51A of the Constitution states that it shall be the duty of every citizen of India to renounce practices derogatory to the dignity of women. Secondly, Section 294 of the IPC provides for penalties for "obscene" acts or conduct. Finally, the Indecent Representation of Women (Prohibition) Act, 1986 prohibits indecent representation of women through advertisement or in publications, writings, paintings, figures or in any other manner. However the lack of gender sensitivity in the media is evidenced by the failure to eliminate the gender-based stereotyping and the reinforcement of women's traditional role that can be found in public and private media. The continued projection of negative and degrading images of women in media communications - electronic, print, visual and audio – is evident. The world- wide trend towards consumerism has created a climate in which advertisements

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and commercial messages often portray women primarily as consumers and target girls and women of all ages inappropriately. Advertisements of beauty products, magazines and beauty pageants mushrooming all over have led to the creation of an image of an "ideal woman". The Indecent Representation of Women (Prohibition) Act was enacted in the year 1986 and since then the issue of what is "obscene" has been a subject of great debate. Even the act is mostly revolved around how the object will affect society and the public morality rather than how it offends women.

The role of the Media in portraying women and the female gender as a whole leaves much to be desired. Press and the print media are generally found to unduly sensationalize traumatic events such as rape etc thereby invading the privacy of the victim. Very few positive stories of girls/ women who have stood up for their rights or are achievers are published. Similarly, the electronic media and films portray serial/ films highly derogatory to women , glorifying subservience of the woman before her husband in laws, celebrating the birth of the boy child and portraying the disappointments of the family at the birth of the girl child, making out eve e teasing / sexual harassment as 'fun' items etc. As a result the general populace are fed on a regular diet of stories/ news that are highly gender abusive, thus reinforcing traditional views that the woman are an inferior race and can be freely exploited. The media has perforce to become gender sensitive and more responsible when portraying the woman and thus play a significant part in bringing about attitudinal changes in the society. A gender friendly media policy needs to be formulated for this purpose.

16. Health and health care.

There is a need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Heath is clearly not the mere absence of disease. Good Health confers on a person or group's freedom from illness and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well-being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care and current bio-medical understanding about health and illness.

Health care covers not merely medical care but also all aspects pro preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure within the government sector alone but must include incentives and disincentives for self-care and care paid for by private citizens to get over ill health. Where, as in India, private out of pocket expenditure dominates the cost financing health care, the effects are bound be regressive. Heath care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible had of the market. Nor can it be established on considerations of utility maximizing conduct alone. First universal access, and access to an adequate level, and access without excessive burden. Second fair distribution of financial costs for access and fair distribution of burden in rationing care and capacity and a constant search for improvement to a more just system.Third training providers for competence empathy and accountability, pursuit of quality care and cost effective use of the results of relevant research. Last special attention to vulnerable groups such as children, women, disabled and the aged.

16.1. Forecasting in Health Sector.

In general predictions about future health of individuals and populations can be notoriously uncertain. However all projections of health care in India must in the end rest on the overall changes in its political economy on progress made in poverty mitigation (health care to the poor) in reduction of inequalities (health inequalities affecting access/quality'), in generation of employment /income streams (to facilitate capacity to pay and to accept individual responsibility for one's health). In public information and development communication (to promote preventive self-care and risk reduction by conducive life styles) and in personal life style changes (often directly resulting from social changes and global influences). Of course it will also depend on progress in reducing mortality and the likely disease load, efficient and fair delivery and financing systems in private and public sectors and attention to vulnerable sections family planning and nutritional services and women's empowerment and the confirmed interest of health care to the largest extent possible. To list them is to recall that Indian planning had at its best attempted to capture this synergistic approach within a democratic structure. It is another matter that it is now remembered only for its mixed success.

16.2. Available health forecasts.

There is a forecast on the new health challenges likely to emerge in India over the next few decades. Murry and Lopez <WorId Bank B 2000> have provided a possible scenario of the burden of disease (BOD) for India in the year 2020, based on a statistical model calculating the change in DALYS are applied to the population projections for 2020 and conversely. The key conclusions must be understood keeping in the mind the tact that the concept of DALYs incorporates not only mortality but disability viewed in terms of healthy years of life lost. In this forecast, DALYs are expected to dramatically decrease in respect of diarrheal diseases and respiratory infections and less dramatically for maternal conditions. Injuries may increase less significantly, the proportion of people above 65 will increase and as a result the burden of non-communicable disease will rise. Finally cardiovascular diseases resulting any from the risk associated with smoking urban stress and improper diet are expected to increase dramatically. Under the same BOD methodology another view is available from a four state analysis done in 1996 <World Bank B 2000> these four states are Andhra Pradesh,

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Karnataka, West Bengal and Punjab represent different stages in the Indian health transition. The analysis reveals that the poorer and more populated states. West Bengal will still face a large incidence of communicable diseases. More prosperous states, such as Punjab further along the health transiting will witness sharply increasing incidence of non-communicable diseases especially, in urban areas. The projections highlight that we still operating on unreliable or incomplete base data on mortality and causes of death in the absence of vital registration statistics and known as yet little about how they differ between social classes and regions or about the dynamic patterns of change at work. It also highlights the policy dilemma of how to balance between the articulate middle upper class demand for more access to technologically advanced and subsidized clinical services and the more pressing needs of the poor for coverage of basic disease control interventions. This conflict over deployment of public resources will only get exacerbated in future. What matters most in such estimates are not societal averages with respect to health but sound data illumining specifically the health conditions of the disadvantaged in local areas <Gwatkin A 2000> that long tradition of health sector analysis looking at unequal access, income poverty and unjustly distributed resources as the trigger to meet health needs of the poor. That tradition has been totally replaced by the currently dominant school of international thought about health which is concerned primarily with efficiency of systems measured by cost effectiveness criteria.

17. Future of State Provided Health Care.

Historically the Indian commitment to health development has been guided by two principles with three consequences. The first principle was State responsibility for health care and the second (after independence) was free medical care for all (and not merely to those unable to pay), The first set of consequences was inadequate priority to public health, poor investment in safe water and sanitation and to the neglect of the key role of personal hygiene in good health, culminating in the persistence of diseases like Cholera. The second set of consequences pertains to substantially unrealized goals of NHP 1983 due to funding difficulties from compression of public expenditures and from organizational inadequacies. The ambitious and far reaching NPP - 2000 goals and strategies have however been formulated on that edifice in the hope that the gaps and the inadequate would be removed by purposeful action. Without being too defensive or critical about its past failures, the rural health structure should be strengthened and funded and managed efficiently in all States by 2020. This can trigger many dramatically changes over the next twenty years in neglected aspects or rural health and of vulnerable segments.

The third set of consequences appears to be the inability to develop and integrate plural systems of medicine and the failure to assign practical roles to the private sector and to assign public duties for private professionals. To set right these gaps demanded patient redefinition of the state's role keeping the focus on equity. But during the last decade there has been an abrupt switch to market based governance styles and much influential advocacy to reduce the state role in health in order to enforce overall compression of public expenditure an reduce fiscal deficits. People have therefore been forced to switch between weak and efficient public services and expensive private provision or at the limit forego care entirely except in life threatening situations, in such cases sliding into in debits. Health status of any population is not only the record of mortality and its morbidity profile but also a record of its resilience based on mutual solidarity and indigenous traditions of self-care assets normally invisible to the planner and the professional. Such resilience can be enriched with the State retaining a strategic directional role for the good health of all its citizens in accordance with the constitutional mandate. Within such a framework alone can the private sector be engaged as an additional instrument or a partner for achieving shared public health outcomes? Similarly, in indigenous health systems must be promoted to the extent possible to become another credible delivery mechanism in which people have faith and away fond for the vast number of less than folly qualified doctor in rural areas to get skills upgraded. Public programs in rural and poor urban areas engaging indigenous practitioners and community volunteers can prevent much seasonal and communicable disease using low cost traditional knowledge and based on the balance between food, exercise medicine and moderate living. Such an overall vision of the public role of the heterogeneous private sector must inform the course of future of state led health care in the country.

18. EMERGING SCENARIO.

What then can we conclude about the prospects of health care in India in 2020? An optimistic scenario will be premised on an average 8% rate of economic growth during this decade and 10% per annum thereafter- If so, what would be the major fall out in terms of results on the health scene? In the first place, longevity estimates can be considered along the following lines. China in 2000 had a life- expectancy at birth of 69years (M) and 73(F) whereas India had respectively 60 (M) and 63 (F). More importantly, healthy life expectancy at birth in China was estimated in the World Health Report 2001 at 61 (M) and 63.3 (F) whereas in Indian figures were 53 (M) and 51.7 (F).If we look at the percentage of life expectancy years lost as a result of the disease burden and effectiveness of health care systems, Chinese men would have lost 11.6 years against Indian men losing 12.7 years. The corresponding figures are 13.2 for Chinese women and 17.5 for Indian women. Clearly, an integrated approach is necessary to deal with avoidable mortality and morbidity and preventive steps in public health are needed to bridge the gaps, especially in regard to the Indian women. Taking all the factors into consideration, longevity estimates around 20-25 could be around 70 years, perhaps, without any distinction between men and women. This leads us to the second question of the remaining disease burden in communicable and non-

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communicable diseases, the effective of interventions, such as, immunization and maternal care and the extent of vulnerability among some groups. These issues have been death with in detail earlier. Clearly an optimistic forecast would envisage success in polio, yaws, leprosy, Kalaazar malaria and blindness. As regards TB it is possible to arrest further growth in absolute numbers by 2010 and thereafter to bring it to less than an million with internationally accepted limits by 2020. With regard to Malaria, the incidence can be reduced by a third or even up-to half within a decade. In that case, one can expect near freedom from Malaria from most of the countries by 2020. As regards AIDS, it looks unlikely that infection can be leveled by 2007. The prognosis in regard to the future shape of HIV / AIDS is uncertain. However, it can be a feasible aim to reduce maternal mortality from the present 400 to 100 per lakh population by 2010 and achieve world standards by 2020. As regards child health and nutrition, it is possible to reach IMRV30 per thousand live births by 2010 in most parts of the country though in some areas, it may take a few years more. What is important is the chance of two thirds decline in moderate malnutrition, and abolition of serious malnutrition completely by2015 in the case of Cancer, it is feasible to set up an integrated system for proper screening, early detection, self-care and timely investigation and referral. In the matter of disease burden as a whole, it is feasible to attempt to reach standards comparable to china from 2010 onwards. Taking the third aspect viz fairness in financing of health care and reformed structure of health services, an optimistic forecast would be based on the fact that the full potential of the vast public health infrastructure would be fully realized by 2010. its extension to urban areas would be moderated to the extent substantial private provision of health care is available in urban areas, concentrating on its sensible and effective regulation. A reasonably wide network of private voluntary health insurance cover would be available for the bulk of the employed population and there would be models of replicable community based health insurance available for the unorganized sector. As regards the private sector in medicine, it should be possible in the course of this decade to settle the public role of private medical practice independent or institutional. For this purpose, more experiments are to be done for promoting public private partnerships, focusing on the issue of how to erect on the basis of shared public health outcome as the key basis for the partnership. A sensible mixture of external regulation and professional self-regulation can be device in the consultation with the profession to ensure competence, quality and accountability. The future of plural systems in medical understanding and evaluation of comparative levels of competence and reliability in different systems a task in which, the separate department for Indian systems of medicine and homeopathy will play a leading role in inducting quality into the indigenous medical practices. The next issue relates to the desirable level of public expenditure towards health services. China devotes 4.5% to its G-DP as against India devoting 5.1%. but this hides the fact that in China, public expenditure constitutes 38% whereas in India, it is only 1$% of total health expenditure. An optimistic forecast would be that the level of public expenditure will be raised progressively such that about 30% of total health expenditure would be met out of public funds by progressively increasing the health budget in states and the central and charging user fees in appropriate cases. The figure mentioned would perhaps correspond to the proportion of the population which may still need assistance is social development. Finally it is proper to remember that health is at bottom an issue in justice. It is in this context that we should ask the question as to how far and in what way has politics been engaged m health care? The record is disappointing. Most health sector issues figuring in political debate are those that affect interest groups and seldom central to choices in health care policy. For instance conditions of service and reward systems for Government doctors have drawn much attention often based on inter service comparison of no wider interest. Inter-system problems of our plural medical care have drawn moreattention from courts than from politics. Hospital management and strikes, poor working of the MCI and corruption in recognition of colleges, dramatic cases of spurious drug supply etc have been debated but there has been no sustained attention on such issues as why malaria recrudescence is so common in some parts of India or why complaints about absence of informed consent or frequent in testing on women, or on the variations in prices and availability of essential drugs or for combating epidemic attacks in deprived areas seldom draw attention. The far reaching recommendations made by the Hathi Committee report and or the Lentin Commission report, have been implemented patchily. The role to be assigned to private sector in medicine, the need for a good referral system or the irrationality in drug prescriptions and sue have seldom been the point of political debate. Indeed the lack luster progress of MNP over the Plans shows political disinterest and the only way for politics to become more salient to the health of the poor and the reduction of health inequalities is for a much greater transfer of public resources for provision and financing as has happened in the West, not only in UK or Canada but in the US itself with a sizable outlay on Medicaid and Medicare.

19. Women and Work Challenges and Recommendations.
Women workers account for about 1/3 of all workers. There are over 397 million workers in India, out of which 123 million are women workers. Only small proportions, 18 million, are in the urban areas while 106 million are in rural areas. Not only do a higher percentage of women than men work in the informal economy, women are concentrated in the lower-income segments, working in survival activities or as casual wage workers or homeworkers. The link between working in the informal economy and being poor is stronger for women than for men. About 30% of the total workers are poor in India (using the 1999 –2000 poverty line atRs.336 per capita per month in rural areas and Rs.451 in urban areas). In general large proportions were poor. Another way of looking at poverty amongst the women workers in India is to compare men and women among the poor workers to their share of the

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total work force. So while 31% of all workers are women, the share of women workers amongst poor workers is 36%. Among the nonagricultural workers, while 19% were women, 24% of the poor agricultural workers were poor. The annual household income of the female headed households was lower compared to male headed households. Within the female headed households, a large proportion of households(44%) were poor, with incomes below the poverty line. The work force participation rates, which shows the proportion of workers in the population indicate that female participation rates are much lower compared to male participation rates. For women, the rates varied across rural (29.9) and urban (13.9)areas while the rates have been almost the same for men. (53.1 & 51.8respectively). The rates have shown a decline over the time period 1993-94 to1999-00 showing a decline in women's participation in labour market activities. The states, which have shown high female participation rates in rural areas, are Andhra Pradesh, Himachal Pradesh and Tamil Nadu. Tamil Nadu also shows a higher female work force participation rate in urban areas. In the North Eastern states of Mizoram and Manipur the workforce participation rates are found to be higher compared to other states. The lowest participation rates are found in Bihar, Tripura and West Bengal.

Special Measures against Trafficking taken by State Governments

State Governments	Special Measures
Andhra Pradesh	Establishment of a State policy for trafficking of women and children, Creation of a Relief Fund for providing relief to trafficked persons; Special rehabilitation measures for *Devadasi*.
Bihar	Establishment of a State Action Plan for the welfare and rehabilitation of trafficked women and child.
Goa	Enactment of Goa Children's Act, 2003
Gujarat	Recognition of homes run by NGOs as protection homes under the ITPA.
Haryana	Creation of Juvenile Justice Fund, Juvenile Welfare Board and Juvenile Courts.
Karnataka	Launching of *Devadasis* rehabilitation scheme
Madhya Pradesh	Launching of *Jabali* Scheme to focus on welfare and development of trafficked women and children.
Maharashtra	Running of 50 family counseling centres by Maharashtra State Social Welfare Advisory Board; Creation of a Monitoring Committee under the chairmanship of a retired judge to monitor working of children's homes; Arrangements for economic empowerment and rehabilitation of devadasis.
Tamil Nadu	Creation of Anti Vice Squad exclusively to deal with trafficking; Creation of District Advisory Committees and Village level Watchdog Committees; Creation of Social Defence Welfare Fund for rehabilitation of women and children; Comprehensive mapping of trafficking in terms of source, transit and destination points; Exposure of women police officials to basic counseling courses; Creation of a crisis intervention centre to prevent child abuse.

Table :2 Special Measures against Trafficking taken by State Governments

20. GENERAL RECOMMENDATIONS IN RELATION TO COMBATTING VIOLENCE AGAINST WOMEN.

20.1. Sensitization.

20.1.1. Promote an active and visible policy of mainstreaming a gender perspective, including VAW in all policies and programmes,

20.1.2. Educate and gender-sensitize the public, police and judiciary. Gender should be made a mandatory part of the curriculum and in-house training of police as it has been found that the present gender orientations are not adequate,

20.1.3. Amend school curriculums to include violence against women and girls and their legal rights and entitlements in an appropriate manner keeping in mind the age of the child etc. This should be done in consultation with women's groups and groups working on education,

20.1.4. Awareness on gender issues in general and violence against women should be included in the core teachers training curriculum, refresher trainings and curriculum of DIETS. The present system of periodic gender orientations is not effective and the change has to be a systemic level,

20.1.5. The Youth ministry should take up VAW/G as a priority issue and encourage interaction with young people, particularly boys. For instance, Jamia Millia University has started a training program for boys in the community on 'gender' to curb violence against women and girls,

20.1.6. Registered SHG federations should be provided training to identify and deal with issues of violence against women. Small funds should be made available with guidelines on spending to enable the federations to assist such women in distress, and

20.1.7. Facilitate the implementation of training programmes for judicial, legal, medical, social services, social work, educational, police and immigration personnel to educate such personnel and sensitize them to the social context of violence against women.

20.2. Support Services.

20.2.1. Every district should minimally have two shelter homes for women and girls. This should be in the nature of a one-stop crisis center where different key services like legal aid, counseling, medical help etc. can be availed. NGOs and government agencies running such centres should be trained adequately,

20.2.2. More counseling centres with qualified social workers cum counselors with good pay packages should be set up. The central social welfare board (CSWB) should ensure regular funding,

20.2.3. A certified course on counseling should be developed and offered through reputed organizations to ensure the availability of counselors especially in rural areas and in small towns where there is acute shortage of such facilities,

20.2.4. Allocations for more medical/trauma centres both separate and within existing government health facilities should be earmarked,

20.2.5. Rehabilitation in terms of capacity building for victims with skills for self-sustenance, property, livelihood, care and protection, can prevent discrimination and stigmatization,

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20.2.6. As more and more people flock into the cities, free night shelters should be built in the urban centers to check trafficking and other forms of violence against women and children,

20.2.7. The experience of setting up women's desks within the police station which is being tried in some states should be studied and if found effective, be up scaled,

20.2.8. Ensure that women subjected to violence have access to law enforcement and justice delivery mechanisms, and

20.2.9. Set up hotlines and helplines providing information, advocacy, support and crisis counselling. Rehabilitation in terms of capacity building for victims with skills for self-sustenance, property, livelihood, care and protection, can prevent discrimination and stigmatization.

20.3. General.

20.3.1. There should be stringent implementation of the existing provisions for prevention of violence against women in which MWCD and NCW should play a monitoring role,

20.3.2. Police has to be accountable for the proper implementation of law, filing of Firs, taking preventive measures

20.3.3. Adequate representation of women in police and judiciary to be ensured with a minimum of at least 33% by the end of XI Plan,

20.3.4. Prison reforms to take care of needs and problems of women prisoners should be carried out,

20.3.5. Adopt, implement and periodically review and analyze legislation to ensure its effectiveness in eliminating violence against women,

20.3.6. Strict action to be taken against community level structures that pronounce anti women judgments and actions in cases like inter-caste or religious marriages, witch-hunting etc,

20.3.7. There should be regular dissemination of information on status of various legal reforms,

20.3.8. Women's organizations should be consulted at all stages of legal reform process,

20.3.9. Self-defense training for girls to be made compulsory in schools,

20.3.10. Women activists taking up cases of violence against women are often threatened and attacked. Strict action should be taken in such cases and the rights of women activists protected,

20.3.11. Support a holistic, multidimensional, multidisciplinary Programme on VAW to be implemented in partnership with the UN System, civil society groups and women's groups/networks,

20.3.12. Support research initiatives on the causes, consequences, costs of and remedies for different forms of VAW, its extent and linkages to other forms of oppression such as class, caste, religion, ethnicity, economic status, occupation,

20.3.13. Support research initiatives exploring the intersectionality of VAW with HIV/AIDS, disability, sexual orientation, migration, disasters and conflicts etc,

20.3.14. Promote research that demonstrates "what works" with regard to addressing VAW,

20.3.15. Ensure that registration of Births, Deaths and Marriages is computerized, and

20.3.16. Registration of marriages should be made compulsory.

21. Health programmes.

The Reproductive and Child Health (RCH) Programme (first phase 1997–2003, second phase starting 2003) has been designed to meet women's needs across their life span. The general objectives of the project include empowering women and children through providing high quality care to them, empowering the community as a whole to demand better health services, and improving substantially the performance of the health care delivery system. The RCH Project, Phase I, as built upon the success of the Universal Immunization Programme and Child Survival and Safe Mother-hood Programme (CSSM). In addition, it covers all aspects of women's health across their reproductive cycle, from puberty to menopause. It gives due importance to male participation in the Programme. The Family Welfare Programme has adopted a Community Needs Assessment Approach since 1997, through a decentralized participatory planning strategy. The preparation of AAP at districts and state levels based on the assessed needs of the people for family welfare services is one of the most vital activities under this approach. The National Maternity Benefit Scheme (NMBS) provides for 100% central assistance to the states/UTs for extending financial benefit of Rs. 500 per pregnancy for first two live births to women who belong to households below poverty line and have attained nineteen years of age and above.

Table: 3 Health Indicators (Comparison)

Health Indicators: A Comparison

Health Indicators	Past Performance	Latest Findings
Crude Birth Rate (Per thousand population)	40.8 (1951)	25.0 (2002)
Crude Death Rate (Per thousand population)	25.1 (1951)	8.1 (2002)
IMR (per thousand live births)	146 (1951–61)	64 (2002)
MMR (per 100000 live births)	437 (1992–93)	407 (1998)
TFR (per woman)	6.0 (1951)	3.2 (1999)
Couple Protection Rate	10.4 (1970–71)	52.0 (2000)
Life Expectancy at Birth	(1951)	(1996–2001)
Male	37.1	63.87
Female	36.1	66.91
Immunisation Status (% Coverage)	(1985–86)	(2003–2004)
TT (for pregnant women)	40	82.9
For Infants:		
BCG	29	102.5
Measles	44	91.8
DPT	41	96.6
Polio	36	97.0

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22. Conclusion.

This global overview shows that while the health of girls and women has much improved over the past 60 years, the gains have been unevenly spread. In many parts of the world, women's lives, from childhood to old age, are diminished by preventable illness and premature death. This year, more than four million girls under the age of five will die from conditions that can, for the most part, be prevented or treated. More than 2.5 million elderly women will go blind for reasons that are similarly avoidable. Between these extremes of the human lifespan, a million women will die from HIV/AIDS, half a million from tuberculosis, and another half a million from complications related to pregnancy and childbirth. This report highlights the commonalities in the health challenges facing women around the world but also draws attention to the differences that arise from the varied circumstances in which they live. The report makes the case that addressing women's health is a necessary and effective approach to strengthening health systems overall action that will benefit everyone. Primary health care with its focus on equity, solidarity and social justice offers an opportunity to make a difference. A startling fact that emerges from the report is the paucity of reliable data. Even maternal mortality, one of the most egregious threats to women's health in the developing world, remains poorly measured. There are gaps in our understanding of the way that most health threats affect females as distinct from males, and of the differential effects on girls and women of health interventions and services. Not enough is known about how health systems should be structured and managed to respond effectively to the particular needs of girls and women especially the poorest and most vulnerable among them. Thus this report is also a call for better data, for more research, for more systematic monitoring of the health of the female half of the world, and for addressing the barriers that girls and women face in protecting their health and in accessing health care and information. In reviewing the evidence and setting an agenda for the future, this report points the way towards the actions needed to improve the health of girls and women. The report aims to inform policy dialogue and stimulate action by countries, agencies and development partners. Improving women's health matters to women, to their families, and to communities and societies at large. Improve women's health improve the world.

Good health is a key criterion, which contributes to human wellbeing and economic growth. Adequate nutrition for women would help them to serve as productive members of the society to develop the consequent health generations. The government should take necessary and compulsory policies to improve the literacy rate and quality education as well as to provide adequate employment opportunities for women, which might explore positive impact on the women's health concerns. The government can also improve the health status of women by strengthening and expanding essential health services as well as by frequent counselling on safe sex, awareness on educational and nutritional needs and gender based violence. The Government knows that there is a need for improvement in health services in rural areas, and, therefore, a time bound programme has been formulated to achieve the desired targets. The National Rural Health Programme launched in 2005, has to provide effective health care to the rural population throughout the country with special focus on 18 States, which have weak public health indicators and/or weak infrastructure. The Mission also aims at raising public spending on health to undertake architectural corrections of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country. The goals of the Mission are reduction in IMR, MMR, universal access to public health services, prevention and control of communicable and non-communicable diseases, including endemic diseases, access to integrated comprehensive primary health care, population stabilization, gender and demographic balance, revitalize local health traditions and medical systems and promote healthy life styles. With the launching of the massive Sarva Shiksha Abhiyan for universalisation of elementary education in the country it has also been decided to make education free and compulsory for all children up to the age of 14 years. This is now a Fundamental Right enshrined in the Constitution. Public spending on education is also likely to increase. Emphasis would be on quality education and girl education. The elementary education programme has shown significant progress. There has been a reduction in the number of out of school children from 44 million in 2001 to 7 million in 2006. The enrolment of girls has gone up by 6.9% from 2001-02 to 2004-05. The dropout rate of girls at the primary stage has reduced by 15% in four years. The thrust of the programme is now to improve the quality of learning and take steps for the appointment of 6.6. lakh teachers to improve teacher pupil ratio, distribute 5.78 crore text books, 20 ensure days of annual in-service training to all teachers and provide for remedial teaching. Women's empowerment is hindered by limited autonomy in many areas that has a strong bearing on development. Their institutionalized in capacity owing to low levels of literacy, limited exposure to mass media and access to money and restricted mobility results in limited areas of competence and control (for instance, cooking). The family is the primary, if not the only locus for them. However, even in the household domain, women's participation is highly gendered. Nationally, about half the women (51.6%) are involved in decision making on their healthcare. Women's widespread ignorance about matters related to their health poses a serious impediment to their well-being. The NFHS-2, for example, reports that out of the total births where no antenatal care was sought during pregnancy, in 60 percent of the cases women felt it was 'not necessary'. And, at a time when AIDS is believed to have assumed pandemic proportions in the country, 60 percent of the ever married women have never heard of the disease. Women's inferior status thus has deleterious effects on their health and limits their access to healthcare. The household has been seen to be a prominent site

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for gender based discrimination in matters of healthcare in a number of other studies too. Marriage in India is predominantly patrilocal with the new bride relocating to her marital house after marriage. Early marriage usually follows a truncated education, disadvantaging girls in many ways. In such a setup, the new bride, already ignorant about health processes, may be in a difficult position to seek healthcare.

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