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ORIGINAL ARTICLE

# SOVEREIGNTY OF WOMEN IN THE FIELD OF HEALTH

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**ABSTRACT**

*WHO estimated that throughout the world approximately 500000 women die every year from pregnancy - related causes. Pregnancy related to death and disabilities result not only in human suffering but also in loss to social and economic development as these women who die are in the prime of life are responsible for the health and well being of their families. Girls marry younger and often at 15 – 16 years and start bearing children. Though it is true in most of the rural areas, even in urban areas women belonging to labour class are also prone to being married off early.*

**KEY WORDS** : Maternal Mortality and Morbidity, Abortion, Nutrition, Environmental influence on health

**INTRODUCTION:**

"Women in Health and Development" was the slogan used in the health sector to characterize the initiative launched during the UN Decade for Women (1976-1985). The concept of the women's health and women's contribution to development were remarkably influenced by the ideas of Primary Health Care and Community participation as strategies for attaining the goals of health for all 2000 AD adopted at Alma Ata in 1977.

According to the integrationist perspective, women's health was considered to contribute towards development in two ways: First, as a means of ensuring biological reproduction and the survival of children maternal care and feeding, and second, as a means of their potential participation in the development of health programs and services to benefit the entire population. In both cases, women were seen as inputs, contributing to the health of the population and the development of the health sector.

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The role of health in bringing about equity between the sexes was scarcely touched upon during the period of integrationism. Equity between men and women was mostly restricted to the search for equal opportunities for both sexes in terms of employment and access to certain positions in the health sector. The motherhood is a women's most important role, and that raising and socializing children as well as caring for members of the family, is women's most effective contribution to all aspects of development.

**FACTORS FOR MATERNAL MORTALITY AND MORBIDITY:**

A maternal death is defined by WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from incidental causes.

WHO estimated that throughout the world approximately 500000 women die every year from pregnancy - related causes. A large proportion of these deaths are attributable to complications of sepsis and hemorrhage are leading cause of maternal deaths occurs in developing countries, where a women's lifetime risk of pregnancy - related death in compounded by the greater number of pregnancies experienced by each women as well as by social-economic conditions and the limited availability of material health services.

Pregnancy related to death and disabilities result not only in human suffering but also in loss to social and economic development as these women who die are in the prime of life are responsible for the health and well being of their families. They generate income, grow and prepare food, educate the young, care for children, the elderly. Beyond the social and economic rationale for preventing this burden of mortality and morbidity has a moral imperative. Pregnancy is not a disease, and pregnancy related mortality and morbidity are preventable with attainable, simple and cost-effective interventions.

Girls marry younger and often at 15 – 16 years and start bearing children. Though it is true in most of the rural areas, even in urban areas women belonging to labour class are also prone to being married off early. Early childbearing has its toll on a woman and underdeveloped pelvis can create complications during labour that last through life. And there are numerous other obstetric problems that plague a too young mother. Repeated pregnancies, coupled with the fact that a young mother does not get enough rest of nourishment through the years of reproduction, take their toll. Often a young woman can succumb to her pregnancy and join the awesome statistics that place the number of deaths resulting from childbirth. When pregnancies come too early or too late in women's reproductive life, when they are too closely spaced or unwanted, those who have already pregnancies that lead to unsafe abortion or to neglect of prenatal care.

The World Health Organization estimated that at least 15 per cent of all pregnant women require skilled obstetric care in the absence of which they will suffer serious and long-term morbidities and disabilities. It is estimated that 127000 women (25 per cent) die due to hemorrhage, 76,000 (15 per cent) due to sepsis 65,000 due to hypertension disorder of pregnancy, 38,000 (8 per cent) due to obstructed labour and almost 70,000 (13 per cent) due to abortion. Around 20 per cent of women die as a result of a disease which are aggravated by pregnancy, such as malaria, iron deficiency, anemia, hepatitis, tuberculosis, heart disease.

Maternal death is the only last chapter in a story that starts much earlier in a women's life. In many parts of the world, girls are subjected to discrimination in terms of the allocation of the family resources and access to health care. Where women's status is low, then health education and emotional needs take second place to those of men.

**ABORTION:**

Globally around 15% of maternal morbidity results from unsafe abortion, and the proportion is high as 50 in same areas. Having a son is like having two eyes, having a girl is like having only one eye says an old proverb, and 80% of Indians still believe it to be true. So it begins, girl foetuses, statistical says are aborted more often. More abortions prone to the amniocentesis test (sex determination) even in advanced stage of pregnancy. A study by a Bombay clinic estimated that above 78000 females fetuses were aborted after sex determination text between 1978-1982 in India.

Unsafe abortion, i.e. the termination of pregnancy performed or treated by untrained or unskilled persons, and its complications are a major direct cause of death among women of reproductive age. The damage to maternal health arises mainly from infection, (the long term consequences of which includes entopic pregnancy, chronic pain and infertility) hemorrhage damage to the cervix or uterus and reaction to anaesthesia and the drugs used to induce abortion.

In India abortions are legal but not readily available and many women continue to rely on unsafe abortion, with detrimental effects to their health. The data are not available on account of death due to abortions.

**NUTRITION:**

It is estimated that about 2,150 million people are suffering from iron deficiency anaemia. About 90 per cent of all anaemia are due to iron deficiency. The high risk of women of fertile age and pregnant women for incurring negative balance and iron deficiency is respectively due to the increased iron needs because of menstruation and the substantial iron demands of pregnancy. Anaemia is the major contributory or sole cause in 20 – 40 per cent of deaths. As it poses a five-fold increase in the overall risk of

maternal death related to pregnancy and delivery. The risk of death increase dramatically in severe anaemia. It is important to realize that severe anaemia is associated with very poor overall socio-economic and health conditions in certain countries and regions of the developing world. As a rule malaria, other infections, and multiple nutritional deficiencies, including folate and vitamin A are also endemic in these populations, iron deficiency, however is responsible for, or contributes significantly to, the majority of anaemia cases during pregnancy. Folate deficiency has also been documented during pregnancy. Often leading to a combined iron folate deficiency anaemia, particularly among lower socio-economic groups causing mostly cereal. based diet aggravated by prolonged cooking and food reheating of liquid preparations.

**ENVIRONMENTAL INFLUENCE ON HEALTH:**

The environment in which people live has a huge influence on their health. For poor people and poor regions, it is the household environment that carries the greatest risk to health. Poor households generally live in a domestic environment with high health risks caused by poor sanitation unsafe water supply, inadequate garbage disposal and drainage, which often leads to diarrhea and respiratory infections. Most of the people suffer due to lack of access to clear and plentiful water and also due to lack of adequate system for disposing of their faces. Faces deposited near houses contaminate drinking water, waste water from the industry flows into rivers, lakes and coastal water with a variety of chemicals and .biological waste and agricultural produce fertilized with human waste are all health hazards. The lack of water supply and sanitation is the primary reason why diseases transmitted via feces like diarrhoea, polio, hepatitis and intestinal parasitic infestations.

**WOMEN'S AUTONOMY:**

Education, work participation and exposure to mass media are some of the means by which women gain status and autonomy, both important aspects of their empowerment. Information was collected in NFHS-2, from the respondents about women's participation in household decision-making, freedom of movement and access to money according to background characteristics.

On the whole, women in Tamil Nadu have greater autonomy. A higher proportion of women in Tamil Nadu are involved in decision making about their own health care, have greater freedom of movement and access to money than among women in Andhra Pradesh. Surprisingly, striking is the low level of freedom of movement in Andhra Pradesh. Only 20 per cent and 15 per cent of women in Andhra Pradesh reported

that they have complete freedom of movement they do not need any permission to go to the market and visit their friends or relatives.

The autonomy of women differs between differential education, religion, caste, occupation and standard of living in the two states. Education of women shows a significant association with the freedom of movement and access to money in Andhra Pradesh. In fact, in Tamil Nadu education of women the association with freedom of movement is found to be significant. Illiterate women in Andhra Pradesh and middle school completed women in Tamil Nadu have greater autonomy in case of decision making about own health care. The Hindu women in Andhra Pradesh while Christian women in Tamil Nadu have greater autonomy. Women who earn cash have more autonomy than other women in the two states. Women who have not worked during the year are more likely to have access to money in Andhra Pradesh. In case of standard of living, 53 per cent of women with a low standard of living and 69 per cent of women with a high standard of living have access to money in Andhra Pradesh while it is 77 per cent and 83 per cent respectively in Tamil Nadu.

**DOMESTIC VIOLENCE : ATTITUDES AND EXPERIENCE:**

There has been increasing violence against women in general, and domestic violence in participation in both developed and developing countries. Both tolerance of and experience of domestic violence are a significant barriers to the empowerment of women, with consequences for women's health, their health seeking behaviour, their adoption of a small family norm, and the health of their children.

Women in Andhra Pradesh are most likely to agree that neglecting the house or children is accounted for 69 per cent followed by wife goes out without telling husband (55 per cent), husband suspects wife is unfaithful (55 per cent) and wife shows disrespect for in-laws (54 per cent) while those it each in Tamil Nadu are 60, 51, 17 and 40 per cent respectively. The percentage who agree with atleast one reason is 79 and 72 for Andhra Pradesh and Tamil Nadu.

Agreement with atleast one reason and with specific reasons for wife beating tends to decline with increasing the level of education in the two states. In Andhra Pradesh the percentage of women who are with at least one reason justifying wife beating among illiterate women was 83 and it has declined to 62 among women who completed atleast high school education and Tamil Nadu it has declined from 76 per cent in illiterate women to 57 per cent among women who complete the high school education.

Christian women in Andhra Pradesh agree with atleast one reason as well as agree with specific reason justifying with beating than Muslim and Hindu women. In Tamil Nadu, Hindu women and Muslim women agree with atleast one reason or with specific

reason for wife beating than Christian women. Table also shows that women belonging to Scheduled Tribes in Andhra Pradesh and Scheduled Castes women except husband suspects wife is unfaithful are more tolerant of wife beating in Tamil Nadu. One possible explanation for this may be that Scheduled Tribes and Scheduled Castes have low literacy status, superstitions beliefs and a high proportion of them living in rural areas than are other castes.

In Andhra Pradesh as well as in Tamil Nadu women who have not in the past 12 months are less likely than women who have worked to agree with at least one reason and also agree with specific reasons except wife shows disrespect to in-laws in Tamil Nadu. In the two states, the proportion of women who agree that wife beating is justified declines as the standard of living increases. The difference is wider between women with low (84 per cent) and high (68 per cent) standard of living in Andhra Pradesh whereas in Tamil Nadu it is 76 per cent and 58 per cent respectively.

**LITERACY STATUS:**

Educational status of the women influences almost every aspect of women's life including her own health. The route of impact is very clear. A literate women gets information more clearly, personally and intimately. She can communicate her opinion to other members of the family with more conviction and confidence. An educated women is respected more than an illiterate women . She is better receptive to good health and hygienic practices.

**NUTRITIONAL STATUS:**

Several studies have pointed out that the vast majority of women in Andhra Pradesh suffer from malnutrition. This was also brought out in NFHS-I and II in Andhra Pradesh (See earlier chapter). The most common health problem among women is anaemia caused by iron deficiency. Anaemia is the major cause of maternal mortality and morbidity (20 to 40 percent death s are caused by anaemia). Women in poor households takes little food (residual of what is left after all members take food) in most cases inadequate or and unbalanced food. This situation causes morbidity among women.

**AGE AT FIRST BIRTH:**

Reproductive health status of women in Andhra Pradesh is poorer than their counter parts even in Bihar and Uttar Pradesh. This is primarily because the age at marriage and age at first birth are as low as 16 and 17 years respectively. They will have a source impact of the health of the mother as well as the child. One of the most significant implementing factors of poor reproductive health status of women in Andhra

Pradesh is the age at first birth. A child giving birth to another child is unimaginable (some girls of less than 15 years also become pregnant and deliver children in Andhra Pradesh). Health and social policy makers should take it up as a challenge to this serious social problem. This is necessary for the sustainable future of healthy population.

**WOMEN EMPOWERMENT– AN EMPIRICAL EVIDENCE:**

In the absence of appropriate measures of empowerment, the commonly found measures like education and employment are used as surrogate measures, while these proxy measures are important and are ideally associated with empowerment, they may not capture all the aspects of the multi-dimensional concept of empowerment. According to Jejeebhoy (1998) three dimensions- decision making, mobility and access to economic resources are clearly related in all settings, irrespective of region or religion.

The National Family Health Survey collected information on a variety of aspects related to the status of women. In the survey, each women was asked six questions to assess their attitude towards wife beating. The question relate to whether according to the respondent, a husband is justified in beating is wife for each of the following reasons, if he suspects her of being unfaithful, if her natal family does not give expected money, jewellery or other items, if she shows disrespect for her in –law, if she goes out without telling him, if she neglects the house on children, or if she does not cook food properly. A women's self worth is considered as high if she does not agree with any of these reasons for justification of a husband to beat his wife, other wise it is low.

In the logistic regression model, we have chosen a women's "self worth" is considered as the dependent variable (high and low) and the following independent variables – involved in decision making health care (Yes/No) freedom of moment (Yes/No) control over resources (Yes/No), education (literate/illiterate), religion (Hindu/Non Hindu) and standard of living (low/high). On the basis of the regression probabilities we have estimated the proportion of women not agreeing for any specific reasons to justify the husband beating his wife (self worth)

**CONCLUSION:**

Improvement in Women's Health status increases the educational and an employment opportunity thereby promotes women empowerment. It also improves the health status of the children. Maternal morbidity and mortality depends on reproductive health care delivery system, nutrition, abortion facilities, environmental sanitation and hygiene and more so women's autonomy and empowerment. In the regression analysis, it is found that three variables, viz., antenatal care, deliveries conducted at medical institutions, and AIDs awareness of women are found to be significantly explaining the variations in

Women Empowerment Index. There are significant educational and socio-economic differentials in women's autonomy.

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