



Does Poor Health Index in India Suggest Trouble for National Reforms Like Women Empowerment as per Sustainable Development Goals or Vice Versa?

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ABSTRACT

Introduction: Evidences suggest gender-integrated interventions, which actively probe to identify and amalgamate activities that get down to the role of gender norms and dynamics, improve national indicators related to female issues. To understand the link between the gender components of interventions and morbidity plus mortality outcomes, it is critical to examine the gender summary measures or composite indices used in evaluations.

Methodology: This study is a secondary data based analytical study which was undertaken to measure and to compare, the women empowerment in terms of their health status indicators in the states of Kerala and Madhya Pradesh. Chi square test was chosen for statistical analysis.

Results: A significant difference was observed between distributions of all the study parameters in both the sample populations.

Conclusion: Certain solutions like, area specific strategic formulation, bridging implementation gaps, overcoming patriarchate bottlenecks and loopholes in legal system, outdo lack of political will and economic backwardness are recommended in full swing, to extirpate the redundant situations in poor performing states with more population load.

Keywords: Health Index, NFHS-4, Women Empowerment, Sustainable Development Goal, NITI Aayog, India.

Note: This article was written before Kerala's flood.

INTRODUCTION

Numerous social, economic and political provisions were incorporated in the Indian Constitution as per ideas championed by our founding fathers for women empowerment. Women in India now participate in areas such as education, sports, politics, media, art and culture, service sector and science and technology. But due to the deep-rooted patriarchal mentality in the Indian society, women are still victimized, humiliated, tortured and exploited. Women are still subjected to discrimination in the social, economic and educational field even after seven decades of Independence.¹

Evidently national indicators related to female is-

ssues can be improved by gender-integrated interventions, which actively seek to identify and amalgamate activities that get down to the role of gender norms and dynamics. To understand the link between the gender components of interventions and morbidity plus mortality outcomes, it is critical to examine the gender summary measures or composite indices used in evaluations.²

Women empowerment refers to increasing the spiritual, political, social, educational, gender, or economic strength of individuals and communities of women.

India is among the few countries where women and men have almost the same life expectation at birth. Women's health in India is an issue that needs attention. Agonizingly, in India irrespective of the worldwide commitment, women from the poorer classes and downgraded areas experience differential access to health care conveniences.

As compared to men, they experience clash exceptionally. As a feature of clash, they are living with distress - be it loss and widowhood with all the disgrace it carries in India; being left as leader of the family without suitable title to property; encountering sexual barbarity; being dislocated and homeless.³

In this regard, the 2030 Agenda for Sustainable Development has a stand-alone goal on gender equality and the empowerment of women and girls. In addition, there are gender equality targets in other Goals, and a more consistent call for sex disaggregation of data across many indicators. SDG is the successor to the Millennium Development Goals (MDGs). The Sustainable Development Goals (SDGs), building upon the Millennium Development Goals, provide impetus for continued action on gender equality by tackling inequalities and empowering women and girls. Goal 5 of the SDGs explicitly links gender equality to health and wellbeing through the key target.⁴

Gender-integrated health interventions include those that are gender transformative and gender accommodating. During promotion of health, gender transformative approaches industriously strive to exasperate and change gender inequalities. These approaches encourage critical awareness of gender roles and norms, they promote the position of women, challenge the distribution of resources. They also delineate allocation of responsibilities between men and women, address power relationships between men and women.²

As cited in Mahua Mandal's study - Keller and Mbewe offer a comprehensive definition of women's empowerment encompassing these concepts: "a process whereby women become able to organize themselves to increase their own self-reliance, to assert their independent right to make choices and to control resources which will assist in challenging and eliminating their own subordination".⁵ Other savants have focused on one central concept; for example, Gita Sen's definition centers on altering the balance of power.⁶ In the era following the 1994 International Conference on Population and Development in Cairo, which articulated a people-centered approach to development, Kabeer's description of empowerment as "the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them" has been widely accepted and used.⁷

Concurrently, governments are concentrating on adding up these interventions to calculate their level of coup and prospective for scale-up. Pointers evinces that gender-integrated interventions construct revamp end results.⁸

As per report of NITI Aayog in February 2018, government think tank believes that the health index will act as a tool to leverage cooperative and competitive federalism, accelerating the pace of achieving health outcomes. It is a weighted composite index based on indicators in three domains: health outcomes (70 % weightage), governance and information (12 per cent), and key inputs and processes (18 per cent). It would also serve as an instrument for "nudging" states and union territories to put much greater focus on output and outcome-based measurement of annual performance.

Given the greater programmatic attention and global political will to improve gender equality for health, especially women's health, it is necessary to examine how gender is measured, particularly in terms of women's empowerment, when evaluating gender integrated health interventions.

Women empowerment in India in various states & union territories is heavily dependent on many different variables that include geographical location (urban/rural), educational status, social status and age. In order to verify reality of difference between certain health indicators of Kerala (model state of India which is comparable to even developed countries) & Madhya Pradesh (empowered action group state of India), this study was done.

METHODOLOGY

This study is a secondary data based analytical study which was undertaken to measure the women empowerment in terms of their health status indicators as per place of residence. Results were also probed for its implication & comparability with 2030 SDGs. Secondary data of National Family Health Survey (NFHS) - 4 regarding women's health status including selected indicators was picked online from the web site of International Institute for Population Sciences (IIPS). As per distribution of study population with their specific indicator values in two different states of India, Chi square test was applied to check whether there is any significant difference between Kerala and Madhya Pradesh results. As per IIPS baseline information, about 11,033 & 62,803 females were interviewed in Kerala & Madhya Pradesh respectively. Out of them as per distribution of population under many health related variables they were grouped into Kerala (urban + rural) & Madhya Pradesh (urban+ rural) sample population respectively.

Women health variables taken under consideration were - Blood sugar level among (age 15-49 years) women, Hypertension among adult (age 15-49 years) women, Women (age 15-49 Years) who have ever undergone examinations of: cervix, breast, oral cavity, Women who have comprehensive knowledge of HIV/AIDS (%), Women who know

that consistent condom use can reduce the chances of getting HIV/AIDS (%), Tobacco use and alcohol consumption among women (age 15-49 years).

These variables were taken into counts and Chi Square analysis was performed on MS Excel to calculate the P values.

Table 1: Distribution of Sample Populations as per various health indicators of NHFS - 4 data in Kerala & Madhya Pradesh

Variables	NFHS 4 Madhya Pradesh Data	NFHS 4 Kerala Data	Chi Square Value	P Value
Blood Sugar Level among (age 15-49 years)Women				
Blood sugar level among ≤ (140 mg/dl)	92.8	86.5	529.53	<0.00001
Blood sugar level - high (>140 mg/dl)	5.1	8.7		
Blood sugar level - very high (>160 mg/dl)	2.1	4.8		
Hypertension among Adults (age 15-49 years)				
Slightly above normal (Systolic 140-159 and/or Diastolic 90-99 mmHg)	6.1	5.5	21.62	7.90*10 ⁻⁵
Moderately high (Systolic 160-179 and/or Diastolic 100-109 mmHg)	1.2	0.8		
Very high (Systolic ≥180 mm of Hg and/or Diastolic ≥110 mm of Hg)	0.6	0.5		
Women Age 15-49 Years Who Have Ever Undergone Examinations of:				
Cervix	24	61.3	6268.79	<0.00001
Breast	10.4	33.4	4163.94	<0.00001
Oral cavity	12.3	50.8	9402.58	<0.00001
Knowledge of HIV/AIDS among Adults (age 15-49 years)				
Women who have comprehensive knowledge of HIV/AIDS	18.1	43.1	3436.46	<0.00001
Women who know that consistent condom use can reduce the chances of getting HIV/AIDS	46.8	74.2	3056.49	<0.00001
Tobacco Use and Alcohol Consumption among women (age 15-49 years)				
Women who use any kind of tobacco	10.4	0.8	1059.66	<0.00001
Women who consume alcohol	1.6	1.6	10506.29	<0.000001
Women who tried to stop smoking or using tobacco in any other form during the past 12 months	38.5	44.6	146.23	<0.00001

All values are in percentage

Results depicted in the table are clearly showing a significant difference in the health status of women of both the states. P values for each & every variable were found to be highly significant. So a significant difference was observed between distributions of all the study parameters in both the sample populations. As Kerala is already maintaining its reputation as a model state in many aspects including human development index etc. in India since last many decades, it's still topping the list in terms of health status of women in comparison to Madhya Pradesh.

DISCUSSION

Below mentioned issues, which are covered under goals of SDGs for women empowerment, are linked with women's health directly or indirectly. So achievement of these goals will certainly improve women health in India or vice versa.

Two of the central goals of SDG dimensions are - Advancing women's political participation/ leadership and economic empowerment.

Women are to be assisted to secure decent jobs, accumulate assets, and influence institutions. There should be public policies, while underlining the

need to recognize, reduce and redistribute the burden on women for unpaid care. Women's role and leadership in humanitarian action, including in conflict-prevention and efforts to ensure peace and security are to be motivated.⁹

It is need of the hour to help governments craft policies and programs to provide water and sanitation to all that respond to women's needs and underpin sustainable services. Gender-responsive budgeting, can channel funds towards measures to improve easy access to safe drinking water so that women have more time to earn an income, girls are more likely to attend school, and family health and hygiene improve.⁹

Multi proponent forum are needed to form thematic matrix for collaboration, partnerships and advocacy for action.

In order to cut the roots of gender discrimination wherever they appear, idea of women's right to equality in all areas must be embedded across legal systems, upheld in both laws and legal practices, including proactive measures such as quotas/reservations etc.⁹

Active efforts to end gender stereotypes must tackle those that limit schooling or channel women and

girls into 'acceptable' areas of study or work. Inclusive & high quality education is to be delivered.⁹

A non-formal educational curriculum is to be constituted to prevent violence against women and girls. All developing regions of the world have achieved – or almost achieved – equal enrolment of boys and girls in primary school. This historic accomplishment is still far from complete. Significantly wide gender gaps are observed in many countries in secondary and tertiary schools.⁹

The highest attainable standard of health is a fundamental right of every person. Gender-based discrimination, however, undercuts this right. It can render women more susceptible to sickness and less likely to obtain care, for reasons ranging from affordability to social conventions keeping them at home.

Ending hunger means that all women can consume enough food with adequate nutrients. Side by side awareness among rural women and decision makers is to be raised, on the need for legal changes to allow more equitable distribution of assets, such as land and credit.⁹

Women have a right to equal access to all avenues, networks to end poverty, from social protection safety nets to use of the latest technology. And this right will be key to achieving the first SDG.

Social norms that treat women as second-class citizens in many cases translate into structural obstacles to progress, such as laws that fail to punish perpetrators of gender-based violence/or budgets that do not fund the services women need most/or improved regulation of global financial markets, different and potentially unequal outcomes for women and men must be then can deliberate actions be taken to correct them, within and across countries.⁹

Cities and human settlements can be safe, prosperous, equitable and pleasant places to live. All elements of urban governance, planning and finance need to actively embed gender equality measures. And to fulfill this, women deserve equal roles in making decisions.⁹

A safe and sustainable future depends on reducing extremes. Women engaged in consumption and production work must have equal access to means such as land and technology that can boost their standard of living. For a better balance in society, women must assume equal leadership - in parliaments and boardrooms, in their communities and families. As poor women are most vulnerable people and are at risk from climate change – they are more likely to perish in disaster stricken situations. For them, the impacts are already a daily reality.

They struggle a lot for long periods in hunting for food, fuel and water, or to grow crops.⁹

So through their experiences and traditional knowledge as stewards of many natural resources, women nexus can offer valuable insights into better managing the climate and its risks. They also have a right to all capacities needed to protect themselves, and to participate in decisions with profound implications for people and the planet.⁹

Our study is clearly showing that the state Kerala which is marching in the direction recommended by SDGs, is an achiever in health status also. The Kerala model is markedly different from the conventional development thinking which focusses on achieving high GDP growth rates. The Kerala model of development, is the style of development that has been practiced in the southern Indian state of Kerala.

This state has achieved improvements in material conditions of living, reflected in indicators of social development, comparable to those of many developed countries, even though the state's per capita income is low. Kerala's 36.96 million (approx..) people may not have experienced rapid growth in GDP per capita, but they have for the past several decades achieved a remarkable social record in terms of adult literacy, infant mortality, life expectancy, stabilizing population growth, and narrowing gender and spatial gaps. As a consequence of all this, women health in Kerala is quite good. So now it's high time for states like Madhya Pradesh to explore for political, social and cultural factors responsible for Kerala's success, in terms of their own state's background. Turning over of human development record relationship with sustainability in environmental terms is highly demanded to get the realistic view, which can be taken of its replicability elsewhere in India.¹⁰

Kerala is topping the list of top 5 states in the health index report with a score of 76.55, prepared by NITI Aayog. Whereas Madhya Pradesh is topping the list of bottom five states with the score of 40.09 and 17th rank. Our statistical results are also matching with the findings of NITI Aayog report. However, it noted that while states that start at lower levels of development are generally at an advantage in notching up incremental progress over states with high health index scores, it is a challenge for states with high index scores to even maintain their performance levels.

Madhya Pradesh shows poor performance, stressing the need to pursue domain-specific, targeted interventions. National programs for the prevention and control of cancer, diabetes, cardiovascular diseases are to be implemented properly in all districts along with adoption of STEPS wise approach

developed by WHO for non-communicable diseases surveillance. Life style modifications are to be adopted. Health education, early diagnosis & prompt treatment are primary and secondary level preventive strategies. All long term and immediate objectives of the national programs are to be hounded.

Many research studies have shown that control of risk factors like alcohol and tobacco consumption etc. has led to 50-80% decline in incidence of cardio vascular diseases in high income countries. We should follow results of these evidence based studies in order to get a grip over the problem. WHO has classified prevention as population based primordial, individual based primary & patient based secondary prevention (WHO 2005). The population approach is used to address the behavioral risk factors at the community level and its success depends upon surveillance, education, partnerships with community organizations, assurance of health services, environment change, and policy/legislative initiatives.^{11, 12, 13, 14}

The high risk individual based prevention approach should assess risk factors to determine individual risk. Secondary prevention strategies, on the other hand, comprise mainly medical interventions in addition to therapeutic life style changes.¹⁵

Objectives of global action plan for the prevention and control of non-communicable diseases (2013-2020) are to be followed. National anti-tobacco program is to be strengthened.

AIDS related issues are to be tackled as per revised guidelines of NACO.¹⁶

Empowerment is an active multi-dimensional process. Although major landmark steps have been taken for women empowerment in India in terms of constitutional rights, acts, policies, schemes etc but women's reservation bill is still pending.^{1, 17, 18}

CONCLUSION

Certain solutions like, bridging implementation gaps, overcoming patriarchate bottlenecks and loopholes in legal system, outdo lack of political will and economic backwardness are recommended in full swing, to extirpate the redundant situations.

Also region specific strategies which include all the relevant background factors, are needed to be designed, after conducting community based need assessment qualitative surveys to bring the desired outcomes.

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