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POPULATION DYNAMICS AND WOMEN'S HEALTH IN INDIA

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Abstract

Women are the half sky of the human universe. It is told that while creating women the Almighty Creator was so kind that He mixed various elements like the gentleness of a lamb, softness of the bubbles of sea water, color of vibjure, fragrance of rose into one admixture and created women. The position and status of women are always the subject matter of discussion, criticism or research since time immemorial. The status of women differs from time to time, community to community, family to family, caste to caste as well. Like all the major religions of the world, Hinduism is a predominantly male dominated religion where women play a secondary role. Women are protected father in childhood, by husband in youth, and by sons in old age. The current article highlights the population dynamics and women's health in India.

Keywords: *Education, Women, Community*

INTRODUCTION

A conspicuous factor in the whole rank talk examined so far is the aggregate nonattendance of any specify of women. As in different parts of the world, women in India have been an abused, oppressed parcel. What has exacerbated things is the additional station mistreatment, notwithstanding sexual orientation misuse and oppression. In this specific circumstance, an investigation of the mistreatment endured by Indian women would be among the most extraordinary. In this way while they have shared natural encounters, their socio political encounters contrast from group to group, area to locale, rank to station and clan to clan. Ladies living in urban working class India think that its hard to identify with women living in a similar city yet having a place with an alternate class.

It is clear that it is almost impossible to posit a monolithic picture of the Indian woman. No woman, anywhere in the world, would perhaps be faced with all dichotomies associated with being born a woman at the same time, as the Indian woman has to face. From the time of her birth, she not only has to contend with having been born a woman, but also takes on identities of caste, class, region and religion. And considering that some of the scriptures placed

women at par with the Shudras and the untouchables, who could be summarily disposed of, one can imagine the added problems for the Indian women.

It is observed that in India, women are supposed to be inferior to men. They are discriminated in every field of life. Sometimes, they have to face discrimination even at work places. India is a growing country. A decent development in each and every field can be seen these days. This is possible due to hard work by people of India. Today, the number of working people is growing at a good pace resulting in more development in the country.

The main reason for this development is that women also start working in the fields which were supposed to be men dominated. There is no field left where no participation of women is found. Today, women can be seen working in factories, military, police services, IT industries etc.

In the lighter version, it looks very motivating that Indian women chose their career themselves and be a part in the development of the country. But, the cruel phase of this fact is that many of these women have to face work place challenges so as to survive in this competition.

In India, there is no such field where women are not treated badly. Yes, not all the women are targeted; but a survey suggests that a decent percentage of working women have to face work place difficulties.

This scenario can be seen from the historic background of India. Till the 19th century, Indian society was supposed to be male dominated. Men used to work and women were supposed to be an object of the house. The situation was such that most of the girls were not sent to the schools for primary education. In this way, women were supposed to be inferior to men.

As the time passes, the thinking of Indian societies start changing. With the introduction of the 20th century, a change in the social status of women was observed. This trend is still growing and now women are able to give competition to men in any field of work.

This is very good scenario for a growing nation but the bad thing is that in some societies, the historic thinking about women can be observed. Therefore, there are some men of lower mentality in the Indian society who still believes that women are inferior to men and are their servants.

Due to this mentality, some women have to face challenges at workplaces. In every field of work, these kind of people can be observed. The suffering women can be married or unmarried. But, if the comparison is made then it can be concluded that married women have to face many challenges as they have family responsibilities as well. They have to maintain a shear balance between work and family.

POPULATION DYNAMICS AND WOMEN'S HEALTH

It is difficult to determine the social status or rank of women, since no uniform indicators of status have been approved. Currently, in most Asian and Pacific countries, women make up the majority of illiterates (75% in South Asia; 70% in China), even in areas that have expanded their educational facilities. East and Southeast Asia have succeeded so far in their attempts to increase the enrollment ratios for women (90% female enrollment ratio as opposed to less than 50% in South Asia). Male-female roles seem to be entrenched in the society of all the countries. Women have benefited from an improvement in health care in East and Southeast Asia. In South Asia, female mortality is still very high. In most of the Asian and Pacific countries, female participation in the labor force is relatively low. However, this may be a misnomer, since the estimates do not include domestic workers that produce familial income. Women in the labor force seem to group into 4 major areas: professional and technical, clerical, service, and production work--all of which are usually low paying, low status jobs. Population growth in developing countries seems to have slowed the advancement of women toward greater gender equality by increasing the dependency burden and limiting social and material resources. High fertility rates among women correlate with an increase in illiteracy and a decrease in status improvement through education. Child bearing and home-making place heavy burdens on those women who marry young because of social pressures. Males are normally educated first in these larger families. The correlation of mortality conditions and female status is not currently clear. Rural-to-urban migration of the husband causes a weakening of the wife's status. Migration of some women to urban areas relieves social pressures and allows them to seek employment, but isolates others from a life with which they are familiar. Higher education of women seems to postpone marriage and child-bearing and increase their power domestically. The relationship between the participation of women in the labor force and fertility is weak. Female education correlates with better use of birth control, greater gender equality, and better child care. Female participation is seen to be necessary if population policies and development programs are to be successful. Increased female participation requires a greater gender equality then is currently seen. Education of women and increased wages through female employment, similar to the situation in Sri Lanka is an effective method of changing the social views of equality.

The concept of the status of women means access to resources such as education, gainful employment, health services, and also the position, power, prestige, or authority that a woman has in various situations. It differs from her role which implies activities, and from

power which refers to influence and control over other persons. A conceptual model is important for operationalizing the problem and scientifically understanding the causal relationship between the dependent variable and the several independent or intervening variables. A comprehensive analytical framework was constructed by listing all the factors that influence the concept of the status of women, and classifying them under 18 major categories. The 18 categories are polity and policy, voluntary efforts, cultural variables, familial variables, marital variables, structural changes, socioeconomic development, urbanization and migration, mortality and unwanted children, norms and variables, attitude, modernization, autonomy and decision, maternal and child health, family planning, role performance, fertility, and overall status of women. Scales to measure status index need to be constructed to make these variables quantifiable. A graphic flow diagram of the conceptual model is presented.

Place of birth and type of assistance during birth have an impact on maternal health and mortality. Births that take place in nonhygienic conditions or births that are not attended by trained medical personnel are more likely to have negative outcomes for both the mother and the child. The NFHS survey found that nearly threequarters of all births took place at home and two-thirds of all births were not attended by trained medical personnel.

While health care is important, there are several other factors that influence maternal mortality and health. Medical research shows that early age at first birth and high numbers of total pregnancies take their toll on a woman's health. Although fertility has been declining in India, as noted earlier, many areas of the country still have high levels.

DISCUSSION

Selected aspects of the model were discussed with interventions. For example, week-long training courses in crafts, sex education, child rearing practices, nutrition and hygiene could be given each summer by health staff, and also given to school students, out-of-school girls, and adult women's groups, for several years until women's status improved. Examples of ways to lessen household drudgery are production of efficient cooking vessels and grinding mills, social forestry close to settlements, and marketing of processed food. These variables must be studied in situations where an increase in women's status leads to conflict with men, evidenced by wife-beating, such as marriages with alcohol abusing husbands, and women with entrenched orthodox religious value systems.

India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the typical female advantage in life expectancy is not

seen in India suggests there are systematic problems with women's health. Indian women have high mortality rates, particularly during childhood and in their reproductive years.

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.

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 25 states and 7 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.

Utter Pradesh, the most populous state in India, has a total fertility rate of over 5 children per woman. On the other hand, Kerala, which has relatively high levels of female education and autonomy, has a total fertility rate under 2. High levels of infant mortality combined with the strong son preference motivate women to bear high numbers of children in an attempt to have a son or two survive to adulthood. Research has shown that numerous pregnancies and closely spaced births erode a mother's nutritional status, which can negatively affect the pregnancy outcome (e.g., premature births, low birth-weight babies) and also increase the health risk for mothers.

Unwanted pregnancies terminated by unsafe abortions also have negative consequences for women's health. Reducing fertility is an important element in improving the overall health of Indian women. Increasing the use of contraceptives is one way to reduce fertility. While the knowledge of family planning is nearly universal in India, only 36 percent of married women aged 13 to 49 currently use modern contraception.

CONCLUSION

More than half of married women with a high school education or above use contraceptives, compared to only one-third of illiterate women. Not surprisingly, the total fertility rates for these two groups are significantly different: 4.0 children for illiterate women compared to 2.2 children for women with a high school education or above. Differentials among the religious groups also are pronounced; e.g., Muslims have the highest total fertility rate and the lowest contraceptive use.

Most women who did not receive health care during pregnancy said they did not because they thought it was unnecessary. Thus, there is a definite need to educate women about the importance of health care for ensuring healthy pregnancies and safe childbirths. Another reason for the low levels of prenatal care is lack of adequate health care centers. It is currently estimated that 16 percent of the population in rural areas lives more than 10 kilometers away from any medical facility.

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