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GENDER ISSUES IN HEALTH: ASSAM VS. INDIA

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ABSTRACT

Health is an important social dimension where gender inequalities are seen . The World Economic Forum (WEF, 2005) made the first attempt to assess the size of gender gap around the world. In this report five critical areas were examined, viz., economic participation, economic opportunity, political empowerment, educational attainment, and health & well-being. The report was prepared for 58 countries including India. No country was observed to have managed to eliminate the gender gap. Those countries that succeeded to a great extent in narrowing the gap were the Nordic countries, with Sweden standing out as the most advanced in the world followed by New Zealand (6), Canada (7), United Kingdom (8), Germany (9) and Australia (10). France (13) ranked ahead of the United States (17.) Since then every year one report is published by the WEF and the numbers of participating countries have also simultaneously increased from 58 in 2005 to 142 in 2014. Gradually the world has managed to reduce the gap to some extent.

KEYWORDS: *Health, gender gap, political empowerment, women empowerment, human development*

1.1 INTRODUCTION

Health is an important social dimension where gender inequalities are seen .The World Economic Forum (WEF, 2005) made the first attempt to assess the size of gender gap around the world. In this report five critical areas were examined, viz., economic participation, economic opportunity, political empowerment, educational attainment, and health & well-being. The report was prepared for 58 countries including India. No country was observed to have managed to eliminate the gender gap. Those countries that succeeded to a great extent in narrowing the gap were the Nordic countries, with Sweden standing out as the most advanced in the world followed by New Zealand (6), Canada (7), United Kingdom (8), Germany (9) and Australia (10). France (13) ranked ahead of the United States (17.) Since then every year one report is published by the WEF and the numbers of participating countries have also simultaneously increased from 58 in 2005 to 142 in 2014. Gradually the world has managed to reduce the gap to some extent. In regard to Health and wellbeing, 96% of gap in health outcome have also been eliminated. In the literature also we have found that health status is an important indicator of empowerment as well as human development. Poor health status of individuals or the society as a whole reflects the poor development status of the country they belong. Similarly women's deteriorating health condition in relation to men depicts the discrimination they faced in their lives. The Fourth World Conference on Women (FWCW) in Beijing, the International Conference on Population and Development (ICPD) in Cairo and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) created the framework for gender equality and women empowerment .This was reinforced by the Millennium Development Goals (MDG), in particular MDG 3, which speaks to gender equality and women empowerment. In all the framework gender issues relating to health was gaining importance. Again WHO releases a report titled Women and health: today's evidence tomorrow's agenda. Four key pillars were identified which are crucial for gender equality and empowerment approach to women's health. First pillar emphasized on gender equality as a key determinant of the health of women. Health of women is influenced mostly by socio cultural, economic and political inequalities confronted by them, Similarly second aspect or pillar gives importance on the fact that health of women must be safeguarded and promoted throughout their life course. Third pillar emphasized on realizing women's right is a basic element for improved health outcomes of women and finally the fourth pillar says engagement of men in improving the health of women. Keeping all these points in view this paper tries to make a humble attempt to analyze the inequality in health among the women of Assam Vis a Vis India.

1.2 OBJECTIVE OF THE STUDY

The main objective of the study is to analyze and compare the gender inequality in Health and demographic features among the women of Assam and India.

1.3 DATA AND METHODOLOGY

Secondary data is used for the study. For Data, Census report of Government of India 2011, Statistical Handbook of Assam, 2014, Economic Survey Reports, Government of India, New Delhi. Reports of Union Ministry of Health and Family Welfare etc. are consulted. For analysis we grouped the study area region wise, on the basis of level of human development and on the basis of income. After that we analyze and compare the indicators using simple statistical tools.

1.4 RESULTS AND DISCUSSION

There are a number of variables through which we can not only make out the health status of individuals but also the extent of inequality between the two sexes. A few of them such as sex ratio, life expectancy rate, maternal mortality rate and infant mortality rate for which comparable data are available are analyzed in the following paragraphs.

1.4.1Sex Ratio:

A fundamental demographic indicator of gender inequality in India, and arguably, one of the most powerful, is the sex ratio. A lower sex ratio, that indicates preference for sons, is so strong that it was manifested as limiting the birth and survival of girls. In 1981 and 1991, the sex ratios at birth were 934 and 927 respectively thus showing a decline in the decade. However, in 2001, it improved marginally to 933 and further to 940 in the year 2011.As regards Assam it has been consistently increasing in Assam. The last Census in 2011 revealed a higher sex ratio (958) for Assam as against 943 at the all India level.

After birth, genetic vulnerabilities result in higher male than female mortality during early childhood in most populations, especially at the neonatal stage. An examination of the trends in the child sex ratios in India, however, revealed a strong female disadvantage in survival. Data revealed a sharp decline in the sex ratio for the population in the age group 0-6 years from 945 to 919 during the last three decades in India. Similar trend was also observed for the state of Assam though data for the initial years 1981 and 1991 were not available. The Census evidence points towards a strict cultural preference for male children as observed from the pattern that emerges across regions. The two kinds of explanation put forward for this deviant pattern are in terms of the practice of female infanticide, and sex-selective abortion as well as female child neglect, none of which is described in terms of its precise magnitude on its bearing on masculinity of sex ratios. While these could be the immediate causes resulting in the distortion of sex ratios, the prime motivation for practice of such measures stems from the preferential sex composition of children. With the ongoing pace of fertility transition, couples are rather forced to achieve a desired sex composition of children within a limited allowance for the number of children. This is mentioned as another dimension intensifying preferential fertility regulation leading to the distortion in sex ratios. With the changing social norms towards smaller family size, the availability and access to new technologies provides an easy way for parents to realize their desired goals. Prof Amartya Sen describes this particular situation as 'technological revolution of a reactionary kind' [CDC, UNFPA]

Table 1.4.1.1: Trend of Sex Ratio in India and Assam

Year	India		Assam	
	Sex Ratio at Birth	Under-Seven Sex Ratio	Sex Ratio at Birth	Under-Seven Sex Ratio
1981	934	962	910	--
1991	927	945	923	975
2001	933	927	935	965
2011	943	919	958	962

Source: Census of India 2011, Govt. of India, Statistical handbook of Assam, 2014

Again Gupta and Kishore (2009) observed that decline over time in the under-seven sex ratio could have one or more of mainly three possible causes: A decrease in the sex ratio at birth due to the use of technologies that enable sex selection; A relatively higher increase in the mortality rate of girl child compared to that of boys; or a systematic undercount of female child compared to male child under the age of seven. Even as the role, if any, of the last of these possible causes is debated, it is commonly accepted that the other two causes, fuelled by strong preference for son and the low status of women in many regions of India, play a substantial role in reducing the under-seven sex ratio.

Table 1.4.1.2 reveals region wise sex ratio at birth and under-seven sex ratio in India and Assam. Southern region witnessed the highest sex ratio whereas North India witnessed the lowest. Coming to the sex ratio within the age group 0-6 years, the lowest under-seven sex ratio was recorded for Northern India and highest for North East. In the context of Assam the sex ratio is the highest in upper Assam and the lowest in lower Assam. However, reverse is seen in case of under-seven sex ratio, which is the highest in lower Assam and the lowest in upper Assam

Table 1.4.1.2: Region wise Sex Ratio in India and Assam 2011			
Country/Region/ State/Sub Region		2011	
		Sex Ratio at Birth	Under Seven Sex Ratio
INDIA	All India	943	919
	North India	918	874
	East India	934	946
	North East India	951	957
	Central India	961	944
	West India	943	908
	South India	1012	949
	Union Territory	953	919
ASSAM	All Assam	958	962
	Upper Assam	959	960
	Central Assam	958	961
	Lower Assam	956	964
Source: Statistical Hand Book, Assam 2014			

Table 1.4.1.3 shows the sex ratio in India and Assam according to the level of human development. It is seen from the table that in case of India, sex ratio is the highest for the very high human development category and the lowest for low human development states. However sex ratio for the age group 0-6 years is the highest for medium human development states followed by very high, low and high human development states. High human development group states has under-seven sex ratio less than that of the national average whereas high and low human development groups have sex ratio at birth less than that of the corresponding figures at the national level. Coming to the context of Assam sex ratio at birth and under-seven sex ratio are same for all the groups irrespective of the level of human development and is also equal to the state average.

Table 1.4.1.3: Sex Ratio in India and Assam according to Level of Human Development			
Region/ Level of human development		2011	
		Sex Ratio at Birth	Under-Seven Sex Ratio
INDIA	Very high	978	928
	High	940	914
	Medium	956	937
	Low	915	919
	All India	943	919
ASSAM	Very high	---	---
	High	958	962
	Medium	958	962
	Low	958	962
	All Assam	958	962
Source: Statistical Hand book, Assam 2014			

Table 1.4.1.4 presents data on sex ratio of India and Assam on the basis of level of per capita income. Sex ratio is the highest for the income group ¹ 50000-¹ 75000 and lowest for the income group ¹ 100000 and above. Under-seven sex ratio in all income groups are lower than the sex ratio at birth and under-seven sex ratio is the highest for lowest income group (below ¹ 50000) and the lowest for the high income states (¹ 75000-¹ 100000). Coming to the context of Assam, sex ratio at birth is equal for low and medium income group and one point lower in high income group. Again under-seven sex ratio is one point lower in below ¹ 25000 group and equal for other income groups.

Table 1.4.1.4: Sex Ratio in India and Assam according to Level of Income			
Region/ Level of human development		2011	
		Sex Ratio at Birth	Under Seven Sex Ratio
INDIA	Below ?50000	947	932
	?50000- ?75000	960	928
	?75000- ?10000	958	901
	?100000 and above	921	907
	All India	943	919
ASSAM	Below ?25000	958	961
	?25000- ?40000	958	962
	Above ?40000	957	962
	All Assam	958	962
Source: Statistical Hand Book, Assam 2014			

1.4.2 Life Expectancy:

In India both genders experienced a continuous rise in life expectancy since 1970s and the transition to female dominance in life expectancy also occurred around 2000(Remo and Saikia, 2013). From the Table 1.4.2.1, it is seen that life expectancy at birth showed an increasing trend both in India and Assam. However female life expectancy was always greater than male life expectancy during the period from 1993 to 2015. The female-male gap in life expectancy was observed to be gradually widening in favor of women both for the state of Assam and the nation as a whole.

Table 1.4.2.1: Life Expectancy in India and Assam (in years)

Year	India			Assam		
	Male	Female	Gap	Male	Female	Gap
1993-97	56.60	57.10	-0.50	60.40	61.80	-1.40
1999-03	57.80	58.30	-0.50	61.80	63.50	-1.70
2001-06	58.96	60.87	-1.91	63.87	66.91	-3.04
2011-15	67.30*	69.60*	-2.30*	66.90	70.90	-4.00

Source: Economic Survey Reports, Government of India, New Delhi. *Union Ministry of Health and Family Welfare.

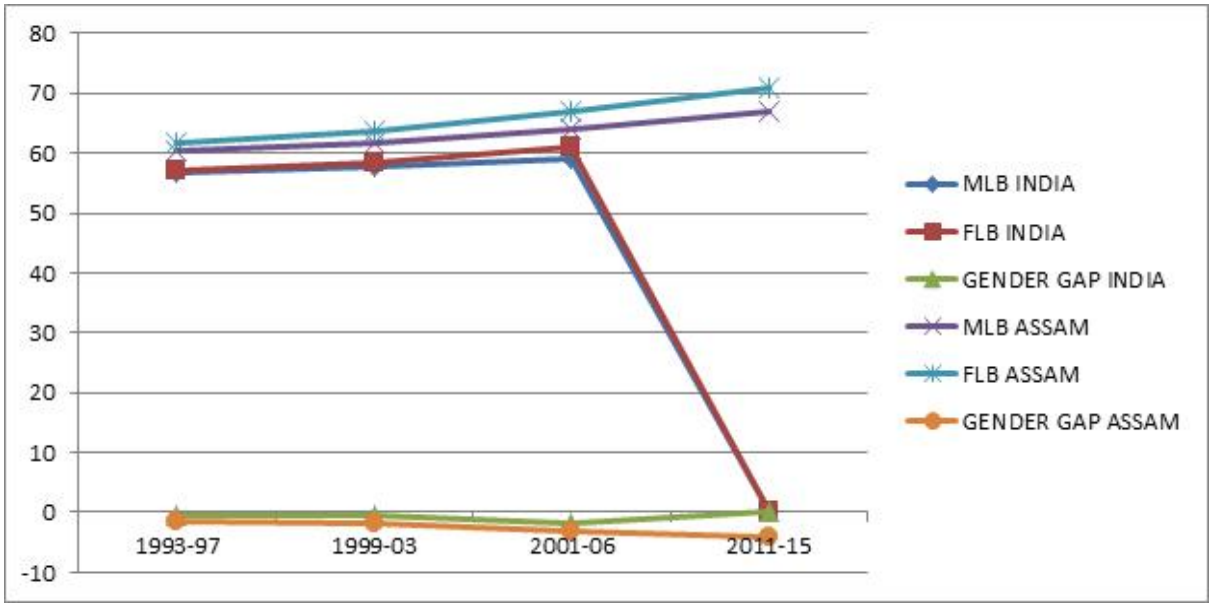

Fig 3.5: Trend of Life Expectancy at Birth, India and Assam

1.4.3. Maternal Mortality Rate and Infant Mortality Rate

Maternal mortality rate and infant mortality rate are two important health indicators revealing the health status of women and children. High values of these indicators are detrimental to the development of women and children and thereby affect overall development of the nation. In Table 1.4.3.1we have presented the trends of maternal mortality rates in India and Assam from 1997-98 to 2015. Though maternal mortality rate gradually declined from 398 in 1997-98 to 139 in 2015, the figure is still higher than the target set by the millennium development goal in India. For Assam MMR was higher than the national average in the entire period. In 1997-98 it was as high as 568 which gradually came down to 328 during 2010-12. But Assam continued to be the state with highest MMR in the country. The worst MMR in Assam, especially in Upper Assam was accounted for mostly in tea gardens. The working class of tea garden is perhaps the most exploited class of the organized sector and most of the women worker in the tea garden are facing discrimination in terms of wage. Their working environment is also not conducive. There is no maternity benefit scheme for tea garden workers. It has been observed that during pregnancy and post natal period, women continue to engage in hard works. Most of the tea garden women are ill feed and malnourished. They suffered from anemia. As a result MMR is very high among the tea garden women workers. A survey done Rane et al (2019) revealed that the Upper Region of Assam comprises of Golaghat, Jorhat, Sivasagar, Dibrugarh and Tinsukia, which are the major tea growing area recorded a very high maternal mortality rate of 436 per lakh women. The study opined that child marriage, absence of maternal health care, lack of positive diet chart are some of the crucial reason sufficing the surprisingly higher MMR. In another study, Dr. Pranoy Phukan, Gynecologists in Assam Medical College rightly pointed out that low literacy rate, poor awareness, poor health services, poor nutrition and habit of these residents to consume salt with tea etc. were the major factors causing alarming rate of MMR in the tea gardens of Assam.

Table 1.4.3.1: Maternal Mortality Rates in India and Assam							
Country/State/ Year	**1997-98**	**1999-01**	**2001-03**	**2004-06**	**2007-09**	**2010-12**	**2015**
India	398	327	301	254	212	178	139*
Assam	568	398	490	480	390	328	Na

*Source: Women and Men in India -2014 16th Issue; Note: * predicted*

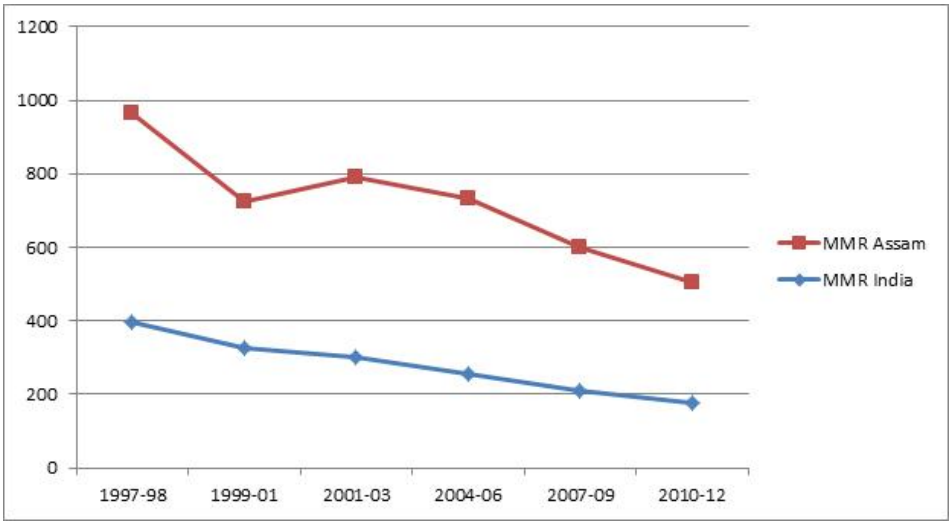

Fig. 3.6: Trend of Maternal Mortality Rate in India and Assam

Table 1.4.3.2 presents data on infant mortality rates for India and Assam for the period from 2001 to 2013. The IMR for both India and Assam reduced considerably from 66 and 74 in 2001 to 44 and 58 in 2013 respectively. However IMR was always lower in India than in Assam. Except 2004, male IMR was always lower than female IMR in India and Assam during the period indicating the strong survival position of male child over female child. In 2004, IMR for both the sexes were equal for India while for Assam male IMR was 21 point higher than that of female IMR indicating a huge gender gap favorable for females. For India, the highest gender gap was seen in 2001 when female IMR was 4 point higher than male IMR. In 2004, the gap was reduced to zero.

Table 1.4.3.2: Infant Mortality Rates in India and Assam								
Year	**India**				**Assam**			
	Male	**Female**	**Total**	**Gender Gap**	**Male**	**Female**	**Total**	**Gender Gap**
2001	64	68	66	-4	69	80	74	-11
2002	62	65	63	-3	70	71	70	-1
2004	58	58	58	0	76	55	66	21
2005	58	61	58	-3	68	69	68	-1
2006	56	59	57	-3	67	68	67	-1
2007	55	56	55	-3	64	67	66	-3
2008	52	55	53	-3	62	65	64	-3
2009	49	52	50	-3	58	64	61	-6
2010	46	49	47	-3	56	60	58	-4
2011	43	46	44	-3	55	56	55	-1
2012	41	44	42	-3	54	57	55	-3
2013	39	42	40	-3	53	55	54	-2

Source: Economic Survey of Assam, 2013-14

1.5 FINDINGS AND CONCLUSION

From this analysis we have found that sex ratio, life expectancy at birth, IMR and MMR had registered an improvement over time both in India and Assam. India's position was better in respect of infant mortality rate and maternal mortality rate in comparison to Assam. However Assam was doing well in respect of, life expectancy at birth, sex ratio at birth and under-seven sex ratio. Though sex ratio at birth for both the regions increased considerably overtime, under-seven sex ratio showed a decline. Gender gap prevailed in health aspects and male IMR was less than female IMR. Female life expectancy was always higher than male life expectancy and thus showing a negative gender gap. Region wise highest sex ratio was seen in Southern States but under seven sex ratio is the highest for North Eastern States. Both were the lowest in North India. Similarly in Assam sex ratio at Birth was the highest in upper Assam region and under seven sex ratio was the highest in Lower region of the state. Sex ratio in India varied directly with the level of human development but with minor deviation but not with income. However under-seven sex ratio did not show any variation along with the level of human development but varied inversely with the level of income. In case of Assam sex ratio at birth and under-seven sex ratio did not change at all along

with the level of human development but slightly changed with the level of income.

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