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GENDER EQUITY IN HEALTH AND EDUCATION: A PARAMETER FOR SUSTAINABLE DEVELOPMENT

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Abstract
*In no country women are treated on par with men and they are usually treated in a biased manner. Integrating women with development process is of vital importance for the chances of economic success. It is impossible to think of a sustainable future leaving behind the capabilities of women. The situation in India is not different from the world's scenario. In recent years the concept of sustainable and inclusive development was given more importance and the women are important dimension of inclusive growth Strategy. Accordingly government has taken various initiatives to improve status of women. Despite these efforts, India accounts for more than 20% of global maternal and child deaths. United Nations calculations show that India's spending on public health provision, as a share of GDP is the 18**th** lowest in the world. The total investment on Health and Education in India remains dismally low. Less than 1% of India's GDP is spent on public health, which is even lower than the public health expenditures of countries like Sri Lanka and Sierra Leone. With this background this paper aims at presenting the problem faced by poor women against a background of depressing statistics which shows how Indian women continued to be denied access to human capital such as health and education which would enhance development of women in particular and sustainable development of the society in general.*
Key words: Women Health, education, economic and human sustainable development

"We talk of revolution, political and economic and yet the greatest revolution is one that affects the status and living conditions of its women (Nehru 1957)".

Introduction

Historically interest has been focused on women's health largely because of their child bearing and rearing role. Recent medical research has bought out long run effect of maternal undernourishment which not only ruins the health of the mother but also cause serious health problems for the children born with low birth weight since they are prone to children's diseases and later in life also to adult diseases. It is estimated that 300-400 million people in India live under absolute poverty of 275 dollars per capita per annum and majority of them are women. The various Human Developments Reports (1990, 2005 and 2010) and World Hunger Report 2016 have concluded that poverty has a decided gender bias. Millennium Development Goal policy and Sustainable Development Agenda also stated that if current trends are not modified, projections indicate that participation of women would lose income earning opportunities. Lifting women out of poverty will dependent to the extent, on a better understanding of how many poor they are, where they live, why they are poor and what their precise circumstances are.

Objectives & Methodology

With this background this paper aims at presenting the problem faced by poor women against a background of depressing statistics which shows how Indian women continued to be denied access to productive assets in the form of human capital such as health and education which would enhance development of women in particular and society in general. The paper also aims at suggesting health development programme for women. The paper is descriptive in nature and is based on secondary data from various sources. The paper is in two part, in the first part of the paper women health disparities are discussed and second part of paper discusses educational disparities of women.

Part 1

Discussion

There is direct relation between women health and economic development. We should not neglect the invisible contribution of women in building the human society. They are the weavers of the fabric of human society and if mother is healthy then only child can be healthy. An economy cannot develop with weaker generation. Women heath is important not for the sake of women but for the sake of human race despite this often women health is neglected. Healthcare services are critical to the overall development of the country particularly to its human development. Indian health sector has made vast improvements over the last past few years. Yet, India' total expenditure in healthcare as a percentage of GDP is still one of the lowest in the world. Though the public health services infrastructure is widespread, starting with sub-centers, primary health centers, community health centers, secondary level district hospitals, up to medical colleges, the quality of these are not uniform and subject to regional vagaries. The conditions of women's lives shape their health in more ways than one. Two things are necessary for good health i. Balanced and Nutritious diet ii. Medical care

Nutrition is a determinant of health. A well balanced diet increases the body's resistance to infection and improper nutritional intake is also responsible for diseases like coronary heart disease, hypertension, non-insulin-dependent diabetes mellitus and cancer, among others. The nutritional status of children and women in India has attracted the attention of academics and policy planners for research. Many studies undertaken by different agencies and researchers have indicated that health indices of male are better than those of female population. There is presence of male female disparities in accessibility, availability of health facilities in India and advocated measures for reducing these inequalities. Accordingly Government of India started various target oriented programme. Despite effort women continue to suffer from poor nutritional status. The discrimination begins at home itself. Indian girl child is disadvantaged from birth (or even before it) due to her sex, and is systematically denied or has limited access to the often paltry food resources within the household. High mortality of women during pregnancy is also one of the reasons for low sex ratio. We can substantiate this argument by looking at the overall maternal mortality rate in India. This coupled with gender bias at health care and less social attention to girl child results in missing women.

Nutritional deficiency

Malnutrition among its citizens is a very severe social problem, as it affects productivity in many ways. The problem of malnutrition is especially critical in case of women and children. A poor nutritional status of women has direct implications on her health as well as the health of her children because a malnourished woman is very likely to give birth to a malnourished child vulnerable to disease and infections. Nutritional deficiency not only retards a child's growth but also affects their future productivity and capabilities' thus adequate nutrition is critical to a child's development.

Table: 1 Trends in nutritional status of children below 3 years

	NFHS-2 (1998-99)	**NFHS-3 (2005-06)**	**NFHS-4 (2015-16)**
Children Stunted (Height for age) %	51.0	44.9	38
Children underweight (Weight for age) %	42.7	40.4	36

Source; National Family Health Survey -3 and 4 (2015-16)

The table 1 shows as per NFHS - 4 that nutritional status of children is strongly related to maternal nutritional status. Nearly 38% of children born are stunted and 36% are underweight due to maternal nutritional deficiency. Therefore to improve the nutritional and health status of children and nutritional supplements to pregnant women and lactating mothers are important.

Infant Mortality Rate

The Infant Mortality Rate (IMR) is the number of death in children under 1 year of age per 1000 live births. The factors influencing infant mortality are the health status of the mothers and the availability of extent of pre/post natal care facilities, general living conditions and economic development of the country and the quality of the environment.

Table: 2 Infant Mortality by Sex

Years	Female	Male	Total
2003	64	57	60
2004	58	58	58
2005	61	56	58
2006	59	56	57
2007	56	55	55
2008	55	52	53
2009	52	49	50
2010	49	46	47
2011	46	43	44
2013	42	39	40
2014	40	37	39

Source: Sample Registration System, Office of Registrar General of India.

Maternal Mortality Ratio

The maternal mortality ratio refers to the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births. Such deaths are affected by

various factors, including general health status, education and services during pregnancy and childbirth. Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. Improving access to ante natal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth will reduce maternal deaths significantly. As reduction in MMR is dependent on various health care factors, the MMR is also used as a measure of the quality of a health care system In India, pregnancy related deaths of women have declined over the years. The number of maternal deaths per year has come down from approximately 1, 00,000 deaths (1991-01) to 44,000 deaths in 2011-13 to 176 per 100,000. Though, more than 50% reduction has registered in the approximate number of maternal deaths in the last two decades, the present status shows that, even now, 120 women die of causes associated with pregnancy, in a day, in India.

Table: 3 Number of Maternal Death /year

Year	Death
1990-91	100,000
2000-01	80,000
2010-11	47,100

Source: Ministry of Health and Family Welfare GoI

Table: 4 Trends in Maternal Mortality Ratio

Year	Maternal mortality rate
1990-91	437
1997-98	408
2000-1	327
2010-11	178
2015-16	167

Source: Sample Registration System, Office of Registrar General of India

The health of women and children is fundamental to development, as reflected in Millennium Development Goals (MDGs) 4 (reducing child mortality) and 5 (improving maternal health and achieving universal access to reproductive health). India has made impressive achievement in MMR over the years. According to the latest SRS estimates, the Maternal Mortality Ratio (MMR) of India is 167 per one lakh live birth (2014-15) as compared to 178 in 2010-12. But there are wide disparities among the states like Kerala (61), Tamil Nadu (79), and Maharashtra (68) have made remarkable progress while some others are lagging behind. But India could not achieve the MDG target level of 109 per 1, 00,000 live births.

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Table: 5 Maternal and Child Health Indicators

	Urban (%)	Rural (%)	Total NFHS-4 (%)	Total NFHS-3(%)
Infant mortality rates (IMR)	29	46	41	57
Mother who had full antenatal care	31.1	16.7	21.0	11.6
Mother who have received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within2 days of delivery	71.7	58.5	62.4	34.6
Institutional birth (%)	88.7	75.1	78.9	38.7
All women age 15-49 years who are anemic (%)	50.8	54.2	53.0	55.3
Children under 5 years who are underweight (weight- - age)	29.1	38.3	35.7	42.5
Women who have comprehensive knowledge of HIV/AIDS	28.1	16.9	20.9	17.3

Sources: NFHS-4

In order to reduce maternal mortality and infant mortality, it is extremely important that all deliveries should be institutionalized and births be attended by skilled health personnel, as timely management and treatment can make the difference between life and death. From above table it is clear that deficiency and gaps in the female health resulted in

vulnerable health state of women. Mothers who had full antenatal care were 31.1 percent in urban area, and only 17 percent in rural areas. Mothers who have received postnatal care were 72 percent in urban and 58 percent in rural areas. Underweight children below 5 years are 29 percent in urban areas and 39 percent in rural areas.

Sex Selective Abortions

The sex selected abortions merits attention not only for itself but also for the range of reproductive health problems that it can engender. Unsafe abortions can lead to infertility, maternal morbidity and mortality, among other undesirable outcomes. Another worrying aspect of abortions in India is the widespread extent of sex selective abortions. The child sex ratio has declined from 927 (2001) to 918 as per 2011 census. A girl child is clearly less wanted especially if a family already has a daughter.

Due to various initiatives undertaken by Government to improved health indicators particularly after the launch of National Rural Health Mission (NRHM) in 2005, significant improvements have been noticed in building the health infrastructure in the country. The visibility of NRHM, now called National Health Mission, is reflected in progress towards achieving targets for the reduction of Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR), Total fertility Rate (TFR) and other indicators. Launch of Janani- Shishu Suraksha Katyakram (JSSK) in 2011 has further strengthened maternal health initiatives by entitling free deliveries and Caesarean-Sections to every pregnant woman coming for deliveries at government health facility.

Over the last few years India has many remarkable improvement in health sector but most of the developments are urban centric. A large number of hospitals, doctors and paramedical professionals are available urban area where only 31.16 percent population lives. Whereas in rural areas where majority of population resides health infrastructure and health facilities are lacking. The major area of concern is availability of manpower/ health staff. For public health services, the manpower in rural areas as per data shows that against the required number, 1, 55,069 of female health worker /ANM at SCs, there are 24,194 vacant positions and there are shortfall of 4679 position. Even at PHCs level, female health assistance, 1013 number of positions are vacant and there is total shortfall of 11,299 positions, for the doctors, 8774 are vacant at the PHCs which is the primary unit for health care need. The CHCs which were established with aim to provide referral and specialist services for the rural population are also having the gaps in terms of required manpower. The data shows that 1811 position of surgeon are vacant. Number of obstetrician and gynecologists vacancy 1859 and shortage of physician is 1989 and pediatrician is 1758.

The poor quality of care (perceived to be) received at the public facilities and the sector's general inaccessibility (in terms of distance, time, and behaviour of staff), and the high costs of the private sector are often the guiding reasons for women to seek the services of the informal sector. Other reasons for seeking such care may include the privacy ensured by the informal sector (especially in sensitive matters like abortion and sexually transmitted diseases) and congeniality of behaviour of the providers. Women experience inferior health status and restricted access to healthcare compare to men. The gendered nature of women's existences is experientially borne out in diverse contexts to produce consistent patterns of vulnerability therein.

Part II

This part of paper aims at discussing gender disparities in education. Gender equality will be achieved only when women and men enjoy the same opportunities, rights and obligations in all spheres of life. Gender equality demands the empowerment of education which is the single most important factor to ensure gender equality and empowerment. Realization of this fact made government to made primary education compulsory to all. As result of various target oriented government initiatives like Sarva Shiksha Abhiyan etc enrolment of girls in primary education, survival and transition to higher levels of education lead to achieving gender parity in education. During 2000-01 to 2013-14, substantial progress has been achieved towards gender parity in education as revealed by some important indicators.

Table 6: Female Enrolment Ratio

Indicators	Level of education	2000-01	2013-14	2015-16
Enrolment of girls as percentage of total enrolment	Primary education(I-V)	43.8%	48.2%	101.4%
	Upper primary education (classes VI-VIII)	40.9%	48.6%	98.9%
	Secondary (IX-X) and higher secondary (XI-XII) education	38.8%	47.1%	65.8%
Number of girls per 100 boys enrolled	Primary education	78%	93%	93%
	Upper primary	69%	95%	95%
	Secondary education	63%	90%	91%
	Higher Secondary education	58%	81%	90%

Source: M/o HRD, Educational Statistics at a glance 2016, M/o HRD.

The Gender Parity Index (GPI) is the ratio of the number of female students enrolled at primary, secondary and tertiary levels of education to the corresponding number of male students in each level. The Gross Enrolment Ratio (GER) is the number of pupils enrolled in a given level of education.

Table: 7 Gender Parity Index (GER) –All India

	1990-91	2000-01	2010-11	2014-15
Primary education	0.76	0.94	1.01	1.03
Secondary education	0.6	0.8	0.88	1.01
Tertiary education	0.54	0.69	0.86	1.01

Source: Ministry of Human Resources Development 2016

At present, in primary education, the enrolment is favourable to females as GPI has crossed the level of 1. In Secondary education also gender parity has been achieved and in tertiary level of education, a rapid progress has been observed during the recent past towards gender parity.

Table: 8 Indicator: Ratio of literate women to men, 15-24 year old

	Male (15-24 yrs)	Female (15-24 years)
1991	73.5	49.3
2001	84.2	67.7
2011	90.0	81.1

Source: Office of Registrar General of India.

The ratio of literate women to men, 15–24 year old (literacy gender parity index) is the ratio of the female literacy rate to the male literacy rate for the age group 15–24. The literacy rate for population in the age group 15-24 years has shown an upward trend both in rural and urban areas and for females as well as males. The youth literacy rate has increased from 61.9% to 86.1% during the period 1991-2011. This period saw a higher increase in literacy rate among female youths (from 49.3% to 81.8%) compared to male youths (from 73.5% to 90%). Over the years, the gap between male and female youth literacy rate has been reduced considerably.

One of the most important dimensions of inequality is gender inequality. Women are generally found to be lagging behind men in every sector including higher education in India as in many countries. During the post-independence period, there is a significant improvement in women's participation in higher education. The total enrolments in higher education have increased from 8.1 percent in 1999-2000 to 21.1 percent in 2013-14. The female enrolment ratio also compared to the earlier decade has improved significantly.

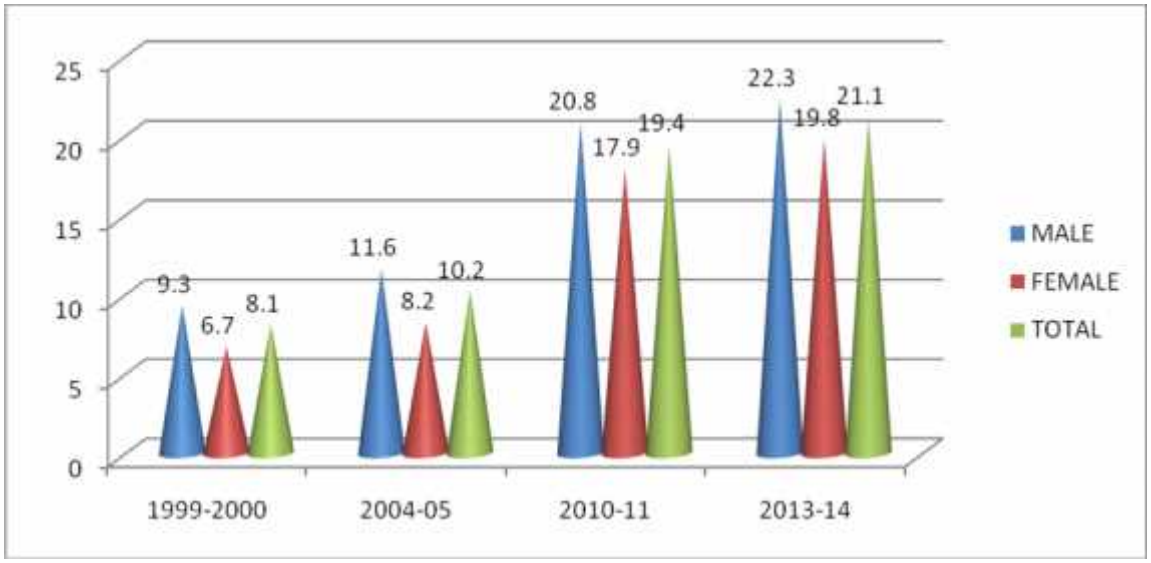

Figure1. Gross attendance ratio by gender (Source: NUEPA 2011and MHRD report 2015)

The overall level of participation of women in higher education has improved remarkably and the current overall level is quite impressive. The gross enrolment ratio among men increased from 9.1 percent in 1999–2000 to 22.3 percent in 2013-14. The rapid improvement in women's status in higher education and thereby a remarkable decline in gender inequality might be attributed to several factors, including specific public policy measures that aimed at promoting women's education. Many states provide free higher education (at least up to first-degree level) and scholarships to women. There are also colleges exclusively meant for women in a majority of states and there are also a few universities only for women. A few states offer reservations for women in admission in higher education institutions. Special measures and special thrust on girls' education at school level also helped in increasing the participation of women in higher education.

Conclusion

To improve the overall human resource conditions and to march towards higher economic growth it is necessary for India to improve the health as well education conditions of women. Government of India has to make serious efforts to correct these gender disparities as we know both education and health are critical requirements to achieve knowledge based growth with sustainability. On one side it plays an important role in poverty alleviation, better health, environmental protection and gender equality and on the other side it provides economic progress, social empowerment and professional success. Sustainability of societal development is the foundation for democracy and therefore, provision of health and education must be equitable, uniformly accessible and of high-quality. The positive externalities of education and health make them a public good, and therefore it needs to be supplied by the state as markets cannot provide it to the socially optimal levels.

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