



MAJOR CONCERNING ISSUES AND CHALLENGES FOR WOMEN'S HEALTH: AN INTERPRETATION

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ABSTRACT

Women and men share many similar health problems, but women also have their own health issues and need to understand systematically. The relation between women's health and the idea of exclusion from different perspectives by mapping out major concerning issues like basic infrastructure facilities (hospitals, schools, public toilets, etc.) for women would be examined.

The present paper is based on the secondary data, i.e. National Family Health Survey (NFHS-4 (2015-16) which shows that above-pointed challenges create an enormous lacuna for women, for instance, the total fertility rates of women are still high and creates health-related challenges for women in rural as well as urban areas. The report shows that there are huge differences in rural and urban areas (in the sense of minimum facilities for women). Therefore, the paper makes an attempt to understand how educational attainments minimize the large socio-economic differences which are closely associated with the health of women.



KEY WORD: Exclusion, women health, education, gender-based violence.

INTRODUCTION

Exclusion in health—understood as the lack of access of certain groups or people to the goods, services, and opportunities that improve or maintain their health status and that other individuals and groups in the society enjoy—has to do with all of these factors (SIDA, 2004). Exclusion in health was defined as the situation in which an individual or a group of individuals do not access the mechanisms that would make possible the satisfaction of health needs. As a result, exclusion in health is understood as the lack of access of certain groups or people to various goods, services and opportunities that improve or maintain their health status and that other individuals and groups in the society enjoy (ibid).

Better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive-, and save more. Many factors influence health status and a country's ability to provide quality health services for its people. Health was seen as not just the absence of ailments but as the total well-being of each person (Gnanadason, 1986). Gender inequality and gender norms and expectations continue to exert a strong influence on the health conditions affecting women and men. Practices such as early and forced marriage, together with poor access to information and education, lack of decision-making power within the couple-, and violence against women increase the exposure of adolescent girls and adult women to sexually transmitted infections-, including HIV (United Nations, 2015)

While women and men share many similar health challenges, the differences are such that the health of women deserves particular attention. Women generally live longer than men because of both

biological and behavioural advantages. But in some settings, notably in parts of Asia, these advantages are overridden by gender-based discrimination, so that female life expectancy at birth is lower than or equal to that of males (World Health Organization, 2009 a). Today, the lives of females of all ages and in all countries are being shaped by a series of factors – epidemiological, demographic, social, cultural, economic and environmental. The same factors influence the lives of males, but some adversities affect girls and women in particular (World Health Organization, 2009 -a).

In India, for instance, the 2001 census recorded only 93 girls per 100 boys – a sharp decline from 1961 when the number of girls was nearly 98. In some parts of India, there are fewer than 80 girls for every 100 boys (World Health Organization, 2009- a).

This research article is divided into different sections in which we will address different issues related to the women and their health issues. This section will analyse the different empirical data shown by the NFHS 4 about the women literacy, decision- making, neonatal care, postnatal care, nutritional status of women and so on.

HOUSEHOLD PROFILE AND WOMEN

Females of age 6 years and above who attend school in the rural areas is only 63% and the rest of them nearly 40 % do not have the education facility. Education facility and health are related, like when women have education, they have good access to a health facility. In Table 1, it is shown that in urban areas as well as rural areas the female population nearly 20% and nearly 40%, did not see the face of the school.

Table 1: Population and Household Profile

Population and Household Profile	Urban	Rural	Total
Population (female) age 6 years and above who ever attended school (%)	80.6	63.0	68.8
The sex ratio of the total population (females per 1,000 males)	956	1,009	991
Sex ratio at birth for children born in the last five years (females per 1,000 males)	899	927	919
Households with an improved drinking-water source ⁱ (%)	91.1	89.3	89.9
Households using improved sanitation facility ⁱⁱ (%)	70.3	36.7	48.4
Households using clean fuel for cooking ⁱⁱⁱ (%)	80.6	24.0	43.8

Source: National Family Health Survey-4, 2015-2016

In other words, we can tell that sex ratio is the important indicator of the social development of the country but National family health survey-4 shows that in per 1,000 males, there are only 956 females in urban areas; perhaps, the condition of total females per 1,000 in 1,009 is a good indicator. But when we see the sex ratio at birth for children born in the last 5 years, it shows nearly the same situation in urban as well as rural areas (Table 1). This is also indicating the female foeticide is killed inside the mothers' wombs. The discriminatory practice is carried out by the society, and some other social culture leads to the killing of female girl children. In India, there is a cultural preference for boys, however, and the most plausible explanation for fewer female than male births seems to be prenatal sex determination, followed by induced abortion of female fetuses (Jha *et al.*, 2006). The research shows the female girl child has more survival capacity than the male child, but it shows (Table1) the discriminatory practice is carried out against the female girl child. For these, the overall sex ratio was still biased against females (Jha *et al.*, 2006).

Research shows that those women who give more time for fetching are not able to give attention to their health issue. In urban areas, only 91.1% of household have access to drinking water facility and the rest of them dependent on some other source. In rural areas, the condition is worse than the urban area where 89.3 % of the population have a drinking water source. Having the rhythm of all of our daily tasks dependent on the once or twice daily fetching of water with the resulting diminishment of time available for other activities is almost beyond the realm of imagination for the adequately supplied water user (Roark, 1984). Women in Third World countries are the carriers of water, the managers of water, and, in general, the guardians of their families' health in terms of water use decisions (Roark, 1984). Women play a central part in the provision, management, and safeguarding of water. Women and girls spend significantly more time acquiring water than men and boys (SIDA, 2015). It is a heavy task that also can expose women to threats of violence and health hazards when they need to go to a far distance to collect water. A focus on gender differences is of particular importance with regard to sanitation facilities. Inadequate access to sanitation and hygiene disproportionately affect poor women and girls, as they are often faced with additional challenges related to menstrual hygiene, personal safety, sexual harassments and violence (ibid). To ignore their natural bodily functions out of fear causes discomfort and also increases the risk of being affected by health problems such as urinary tract infections, chronic constipation and mental stress (ibid).

The global importance of water, sanitation, and hygiene for development, poverty reduction and health are reflected in the United Nations Millennium Declaration, in particular, its eight Millennium Development Goals, in the reports of the United Nations Commission on Sustainable Development and at many international for a (Prüss-Üstün *et al.*, 2008). An important share of the total burden of disease worldwide—around 10%—could be prevented by improvements related to drinking water, sanitation, hygiene and water resource management (ibid).

Women washed domestic utensils and clothes on the canal because it saved them time and effort. If they had no household connection, they had to carry water into the house from a public standpipe (Watts, 2004). However, water management may also be a health issue in large villages; and peri-urban communities are supplied with piped water but have inadequate sanitation or drainage facilities (ibid). Women play a major role in domestic water management in areas where safe water and drainage are not available in the house (ibid).

Globally, the proportion of the population with access to improved drinking-water sources increased from 76% to 86% between 1990 and 2006. Since 1990, the number of people in developing regions using improved sanitation facilities has increased by 1100 million. Nevertheless, in 2006, there were 54 countries in which information was available where less than half the population used an improved sanitation facility (World Health Organization, 2009b). Sanitation facility is directly related to the health of the population, but in the rural areas, the population of more than 60 % did not have the facility of the sanitation. Lack of safe water and poor sanitation are important risk factors for mortality and morbidity, including diarrhoeal diseases, cholera, worm infestations and hepatitis (World Health Organization, 2009b). In contrast to the rural areas, the urban areas have some improved facility of the sanitation available to them. Most of the communicable diseases have erupted in the rural areas due to the non- facility of sanitation and the people dwelling reside in that areas.

WOMEN AND COOKING

Biomass fuel remains a widely used energy source in rural India (Table 1) where nearly 76 % of households use them as the primary cooking fuel. In contrast, the majority of urban households use liquefied petroleum gas (LPG) as the primary cooking fuel; however, nearly 20 % of urban households use biomass fuel for cooking purposes (Sehgal *et al.*, 2014). Solid fuel or biomass fuel refers to the use of cheap materials such as wood, crop residues, or cow dung for cooking or heating purposes, mainly in the poorer regions of the world (Sehgal *et al.*, 2014). Women are in charge of cooking. Day after day, and often throughout the course of a lifetime, they spend many hours in the vicinity of the fire or stove (World Health Organization, 2006 c). Use of biomass fuel leads to harmful health effects due to the emission, during its incomplete

combustion, of a large number of air pollutants such as carbon monoxide (CO), sulphur dioxide (SO₂), respirable particulate matter (PM_{2.5} and PM₁₀), polycyclic aromatic hydrocarbon (PAH), benzene, and metals like lead and copper (Sehgal *et al.*, 2014). The inefficient burning of solid fuels on an open fire or traditional stove indoors creates a dangerous cocktail of hundreds of pollutants, primarily carbon monoxide and small particles, but also nitrogen oxides, benzene, butadiene, formaldehyde, polyaromatic hydrocarbons and many other health-damaging chemicals (World Health Organization, 2006c). Women exposed to indoor smoke are three times more likely to suffer from chronic obstructive pulmonary diseases (COPD), such as chronic bronchitis or emphysema, than women who cook with electricity, gas or other cleaner fuels. Coal use doubles the risk of lung cancer, particularly among women (ibid).

WOMEN AND LITERACY

It has been reported that higher maternal mortality is among illiterate women, compared to higher-educated women (Gupta *et al.*, 2012). Women health is directly influenced by the education of women. In Table 2, only 61 % of women are literate, and the rest of them are illiterate; out of them, only 27.3 percent have the 10 years of schooling in rural areas. Rests of them, nearly 70 % are dropouts from school. In a global comparison, there is a strong positive association between the level of development of a country and educational attainment – a proxy for the level of human capital – for both men and women (OECD, 2012). The more education a girl receives, the less likely she is to marry a child. Improving access to education for both girls and boys and eliminating gender gaps in education are important strategies in ending the practice of child marriage (UNICEF, 2005). It is time—indeed past time—to give substantially greater attention to the role that early marriage plays in potentially exposing girls and young women to severe reproductive health risks, including HIV (Bruce and Clark, 2004).

Table 2: Characteristic of Adults

Characteristic of Adults (age 15-49)	Urban	Rural	Total
Women who are literate (%)	81.4	61.5	68.4
Women with 10 or more years of schooling (%)	51.5	27.3	35.7

Source: National Family Health Survey-4, 2015-2016

Direct effects of education on economic participation, education also affects other societal outcomes such as child mortality, fertility, personal health outcomes, and greater investment in the education and health of future generations (OECD, 2012). With many countries mandating schooling from around the age of 6 years onwards, primary school enrolment is nearly universal in most regions in the world (OECD, 2012). But from Table 1, it shows that population (female) of age 6 years and above have only 63% of school attendance in rural areas which indicate that nearly 37 % of the female shortfall in school attendance in the age of 6 years. Even the urban areas are also not showing the good data about the attendance of females, where it is only 80 %, and it has become 20 % of the shortfall. Table 2 shows that the literacy of women in rural areas is only 61% which is not a good indicator. These high levels of illiteracy contribute significantly to the disease burden of poor communities and countries and reinforce health and economics inequalities (Kickbusch, 2001). It is estimated that two-thirds of the world’s 960 million illiterate adults are women. All countries ranked in the top 10 for ‘women’s well-being’ have a female literacy rate of 90% and higher. In contrast, Africa has the lowest rate with wide disparities (ibid.). Investments in education determine women’s ability to earn higher wages and to own and operate productive farms and firms (World Bank, 2012). Educating girls and women, improving health outcomes in childhood, lowering the risks of giving birth, and addressing skewed sex ratios at birth (ibid.) through the education bring good health outcome to women. Better-educated women are more likely than others to desire smaller families and hence have a stronger motivation to practice contraception. Educated women are also less prone to have a fatalistic attitude toward life and to accept the unpredictability of unregulated fertility (Martin, 1995). But

access to fertility regulation can also be seen as a factor contributing to the improvement of women's status in general and women's education in particular (Martin, 1995). The level of education of women is a socioeconomic indicator that is frequently found to be negatively related to fertility. A more detailed analysis may show that among educated women marriage is relatively late or the use of contraception more frequent, thus clarifying the relationship between education and fertility (Bongaarts, 1978).

WOMEN AND FERTILITY OR AGE OF MARRIAGE

Fertility is usually higher in rural areas than in urban areas, higher among uneducated women than among their better-educated counterparts, and higher in households with low incomes (Bongaarts, 2011). Children per women (TFR) in rural areas are more than those the urban areas. Total fertility rate (TFR) in rural areas is 2.4, whereas it is 1.8 in urban areas. The uneducated women from rural areas (see Table 1 and 2) are higher than in urban areas. These relations show the rural women have higher (TFR Table 3) than the urban women in relation to the education and literacy.

Table 3: Marriage and Fertility

Marriage and Fertility	Urban	Rural	Total
Women age 20-24 years married before age 18 years (%)	17.5	31.5	26.8
Total fertility rate (children per women)	1.8	2.4	2.2
Women age 15-19 years who were already mothers or pregnant at the time of survey (%)	5.0	9.2	7.9

Source: National Family Health Survey-4, 2015-2016

Contraceptive practice in India is known to be very heavily skewed towards a terminal method, which means that contraception in India is practiced primarily for birth limitation rather than birth planning (Chaurasia, 2014). However, current uses of family planning method by married women of age 15-49 years are 51% in rural areas and 57 % in urban areas in which female sterilization (Table 4) is more than male sterilization. Female sterilization is nearly equal in both rural and urban areas, and in the same proportion, the male sterilization in urban and rural areas.

Table 4: Current use of family planning method

Current use of family planning method ^{iv}	Urban	Rural	Total
Any method ^v (%)	57.2	51.7	53.5
Any modern method ^{vi} (%)	51.3	46.0	47.8
Female sterilization (%)	35.7	36.1	36.0
IUD/PPIUD (%)	2.4	1.1	1.5
Male sterilization (%)	0.3	0.3	0.3
Pill (%)	3.5	4.3	4.1
Condom (%)	9.0	3.9	5.6

Source: National Family Health Survey-4, 2015-2016

It is already shown that women from rural and urban areas use family planning in the same percent, but compared to male sterilization, female sterilization is more in rural as well as the urban areas. From the

Table 4, it is shown that female sterilization is 36% in rural areas as where we can see that males got only 0.3 % of sterilization. In the case of urban areas, the result is not different from that in rural areas.

In all the countries surveyed, the proportion of women not wanting any more children rises sharply with increasing maternal age and parity, as does the risk of maternal death—a fortunate convergence between women’s childbearing desires and a factor that could reduce the risk of maternal death (Rosenfield and Maine,1985). However, in India, Table 3 shows that women of age 15-19 years who were already mothers or pregnant in rural areas is 9.2 % and 5% in urban areas. In addition, women of age between 20 and 24 years who got married before the age of 18 years is 31% in rural areas and 17% in urban areas; this increases the risk of maternal death in India.

WOMEN AND MATERNITY CARE

Neonatal protected against tetanus is 88.6% in rural areas and 89.9% in urban areas (Table 5).Almost 20% of all deaths are of children less than 5 years old. Neonatal mortality (deaths during the first 28 days of life per 1000 live births) accounts for a large proportion of child deaths in many countries. Neonatal mortality rates are considered as a useful indicator of overall maternal and newborn health and the care that mothers and babies receive (World Health Organization, 2009). Most neonatal deaths (99%) arise in low-income and middle-income countries, and about half occur at home. In poor communities, many babies who die are unnamed and unrecorded, indicating the perceived inevitability of their deaths (Lawn *et al.*, 2005).

The study shows that approximately three-fourths of all pregnant women were found to have some form of anemia. It appears that the identification and referral of anemia cases seem to have increased. Anemia is a known major risk factor for maternal mortality, and high prevalence of anemia in these women should also be seen as a reflection of the suboptimal quality of antenatal care services (Gupta *et al.*, 2012).

It is noted from the Table 5 that mothers who have accesses to iron-folic acid are only 25.9 % in rural areas while 50% in urban areas. But a study noted eclampsia, pre-eclampsia, and anemia as the most common underlying causes of maternal deaths. The high number of cases of eclampsia indicates poor antenatal care and poor and untimely referral (Gupta *et al.*, 2012). The high rate of anemia among the study women demands immediate attention during the antenatal period (*ibid.*).

At the individual level, there are sound clinical reasons for believing that the risk of maternal death can be reduced by skilled attendance, particularly as the causal pathways can be specified (Graham *et al.*, 2001). Table 5 shows that mothers who received postnatal care within 2 days of delivery from a skilled attendance (doctor/nurse/LHV/ ANM/ midwife/ other personnel) are 58 % in rural areas and 71% in urban areas. Rest of them that is 40% in rural areas and 30 % in urban areas, do not have the accessibility of skilled attendance, which may cause risk to the maternal death. At the individual level, there are sound clinical reasons for believing that the risk of maternal death can be reduced by skilled attendance, particularly as the causal pathways can be specified (Graham *et al.*, 2001). It is estimated that around 16% -33% of all maternal deaths may be avoided through the primary or secondary prevention of four main complications (obstructed labour, eclampsia, puerperal sepsis and obstetric haemorrhage) by skilled attendance at delivery (*ibid.*).

Table 5: Maternity Care

Maternity Care (for last birth in the 5 years before the survey)	Urban	Rural	Total
Mothers who had an antenatal check-up in the first trimester (%)	69.1	54.2	58.6
Mothers who had at least 4 antenatal care visits (%)	66.4	44.8	51.2
Mothers whose last birth was protected against neonatal tetanus ^{vii} (%)	89.9	88.6	89.0
Mothers who consumed iron-folic acid for 100 days or more when they pregnant (%)	40.8	25.9	30.3

Mothers who had full antenatal care ^{viii} (%)	31.1	16.7	21.0
Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	87.7	90.0	89.3
Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	71.7	58.5	62.4
Mothers who received financial assistance under Janani Suraksha Yojana (JSY) for births delivered in an institution (%)	21.4	43.8	36.4
Average out of pocket expenditure per delivery in public health facility (Rs.)	3,913	2,947	3,198
Children born at home who were taken to a health facility for a check-up within 24 hours of birth (%)	3.2	2.4	2.5
Children who received a health check after birth from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of birth (%)	27.2	23.2	24.3

Source: National Family Health Survey-4, 2015-2016

Postnatal care of women is getting only 58 % (Table 5) whereas we can see that registration of pregnant women in rural areas is 90 %. In the post-neonatal period, girls experience slightly higher mortality than boys. Female children are unusually disadvantaged in the next 4 years of life. Child mortality (ages 1–4 years) is 43 % higher for females (42.0 per 1,000) than for males (29.4 per 1,000) (Mutharayappa *et al.*, 1997).

Table 5 shows that *Janani Suraksha Yojana* (JSY) have received only by 43.8 % in rural areas and 21.4 % in urban areas; however, almost 85% of the beneficiaries belonged to socially-disadvantaged class (scheduled caste, scheduled tribe, and other backward classes), (Gupta *et al.*, 2012), which leads to nearly 50 % of women who are not able to get the financial beneficiaries from the JSY in rural areas and more than 80% in urban areas.

It is observed that there is an increase in institutional delivery among the illiterate and lower socioeconomic class covered by *Janani Suraksha Yojana*(JSY), indicating that the scheme is reaching the target population who earlier preferred home deliveries due to lack of education and poverty. However, the proportion of the illiterate beneficiaries was still small compared to the total beneficiaries (Gupta *et al.*, 2012).

Children born at home are not able to get the medical facility; the ratio of children getting the medical facility is very less in rural areas as well as in urban areas. The children who are born at home who were taken to a health facility for a check-up within 24 hours of birth is 2.4 % in rural areas and 3.2% in urban areas.

Institutional Birth and Women

Table 6: Delivery Care

Delivery care (for births in the 5 years before the survey)	Urban	Rural	Total
Institutional births (%)	88.7	75.1	78.9
Institutional births in public facility (%)	46.2	54.4	52.1
Home delivery conducted by skilled health personnel (out of total deliveries) (%)	3.0	4.9	4.3

Births assisted by doctor/nurse/LHV/ANM/other health personnel (%)	90.0	78.0	81.4
Births delivered by caesarean section (%)	28.3	12.9	17.2
Births in a private health facility delivered by caesarean section (%)	44.8	37.8	40.9
Births in a public health facility delivered by caesarean section (%)	19.9	9.3	11.9

Source: National Family Health Survey-4, 2015-2016

Delivery care is still behind in India where (Table 6) only 75.1% of children are born with institutional birth and the rest of them inside the home by a traditional worker. However, 54 % is institutional births in public facility in rural areas and the rest of them may be in a private facility. In urban areas, only 46 % of public institutional births are there, and a large number are preferred to the private facility. A study suggests that between about 16% and 33% of all maternal deaths could be avoided through skilled attendance, assuming certain competencies as well as the availability of essential, drugs, equipment and referral (Graham *et al.*, 2001). There were higher risks of maternal death for those conducted by non-professionals compared to women delivering with health professionals (*ibid.*).

The estimated proportion of births by caesarean section in the population is not less than 5% or more than 15%. It should be noted that the proposed upper limit of 15% is not a target to be achieved but rather a threshold not to be exceeded. Nevertheless, the rates in most developed countries and in many urban areas of lesser-developed countries are above that threshold (World Health Organization, 2009d). As we can see that from Table 6, birth delivered by caesarean section in rural areas is 12.9 % and 28.3% in urban areas. But birth in a private health facility delivered by caesarean section compared to birth in a public health facility delivered by caesarean section is high. This result shows that this raises the possibility that some of these operations are performed (or not) for financial, rather than medical, reasons (World Health Organization, 2009d)

Table 7: Nutritional Status of Adults

Nutritional status of adults (age 15-49 years)	Urban	Rural	Total
Women whose Body Mass Index (BMI) is below normal (BMI <18.5 Kg/m ²) ^x (%)	15.5	26.7	22.9
Women who are overweight or obese (BMI ≥ 25.0 kg/m ²) ^x (%)	31.3	15.0	20.7

Source: National Family Health Survey-4, 2015-2016

Women who have a low body mass index suffer from the anemia and other related diseases which cause the death of the people. In the rural areas women who have the low body mass index and in the urban areas, women have the overweight, or obese problem leads to a cardiovascular problem to the women, which cause the death of the people. In Table 7, it is shown that women from the rural areas have nearly 30 % of women living below the low body mass index, and in contrast, the urban areas women have 15 % in the obese.

WOMEN AND GENDER-BASED VIOLENCE

Gender-based violence defines violence that is directed against a woman because she is a woman or that affects women disproportionately (Krantz, 2002). Violence against women affects all spheres of a woman’s life—her autonomy, her productivity, and her capacity to care for herself and her children and subsequently also her overall health status and quality of life (ibid.). The most common form of violence that women experience is from an intimate partner (IPV). This violence may be physical, sexual, or emotional (Devries *et al.*, 2013). While violence against women is an almost universal phenomenon, there are isolated examples of societies where gender-based violence does not exist (Heise *et al.*, 1994). Gender-based violence includes a host of harmful behaviours that are directed at women and girls because of their sex, including wife abuse, sexual assault, dowry-related murder, marital rape, selective malnourishment of female children, forced prostitution, female genital mutilation and sexual abuse of female children (ibid.). From Table 8, it is shown that women from rural areas have more spousal violence than urban women. Women even in the period of pregnancy face violence in rural areas as well as in urban areas. Violence against women also has a profound impact on development. It perpetuates poverty by reducing women’s capacity to work outside the home, their mobility and access to information, and children’s school attendance (Krantz, 2002). Women's access to health care is theoretically equal; some women are more vulnerable to receiving inadequate or insufficient care as well as to experiencing violations of dignity (Mann and Gruskin, 1995). Violence against women is a significant health and social problem affecting virtually all societies, but often it goes unrecognized and unreported, and in many countries, it is still accepted as part of normal behaviour (Krantz, 2002).

Table 8: Women Empowerment and Gender-Based Violence

Women empowerment and gender-based violence	Urban	Rural	Total
Currently marriage women who usually participate in household decision(%)	85.8	83.0	84.0
Women who worked in the last 12 month who were paid in cash (%)	23.2	25.4	24.6
Ever-married women who have experienced spousal violence (%)	23.6	31.4	28.8
Ever-married women who have experienced violence during pregnancy (%)	2.9	3.5	3.3
Women owing a house and/or land (alone or jointly with others) (%)	35.2	40.1	38.4
Women having a bank or savings account that they themselves use (%)	61.0	48.5	53.0
Women having mobile phone that they themselves use (%)	61.8	36.9	45.9
Women age 15-24years who use hygienic methods or protection during their menstrual Period ^{xi} (%)	77.5	48.2	57.6

Source: National Family Health Survey-4, 2015-2016

CONCLUSION

This study empirically provided enough evidence of the existence of exclusion of women in our society, and it is the cause for health exclusion of women. They are excluded from every aspect of the life. They are excluded from the taking education the result shows that women are still not able to get the education. A larger number of women facing the discrimination in the family like education, nutritional status, and health facility. The available facility is also not giving proper services to the women who are considered to the exclude. Ill health of women, high maternal mortality rate, high infant mortality, less antenatal care and institutional deliveries lead to the exclusion of the women. It is also important to notice here that health-seeking behavior is preceded by a decision-making process that is further governed by individuals and/or household behavior, community norms, and expectations as well as provider-related

characteristics and behavior. The health-seeking behaviour of women very less because the process of exclusion continues since independence.

NOTES

- ⁱ Piped water into dwelling/yard/plot, public tap/standpipe, tube well or borehole, protected dug well, protected spring, rainwater, community RO plant
- ⁱⁱ Flush to piped sewer system, flush to septic tank, flush to pit latrine, ventilated improved pit (VIP)/biogas latrine, pit latrine with slab, twin pit/composting toilet, which is not shared with any other household
- ⁱⁱⁱ Electricity, LPG/natural gas, biogas
- ^{iv} Currently married women age 15–49 years.
- ^v Includes other methods that are not shown separately
- ^{vi} Includes other methods that are not shown separately
- ^{vii} Includes mothers with two injections during the pregnancy of her last birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last birth. Not exactly comparable with NFHS-3 due to differences in definition.
- ^{viii} Full antenatal care is at least four antenatal visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets or syrup taken for 100 or more days
- ^{ix} Excludes pregnant women and women with a birth in the preceding 2 months
- ^x Excludes pregnant women and women with a birth in the preceding 2 months
- ^{xi} Locally prepared napkins, sanitary napkins and tampons are considered as hygienic methods of protection

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