

The Indentation of Gender Inequality on Health of the People of Uttar Pradesh

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ABSTRACT

The National Family Health Survey (NFHS), the fourth in series, provides information on population, health, and nutrition for India and each state and union territory. The most populous state of India is not doing well in many indicators and understanding them from different perspectives is imperative for translational changes in the future. The secondary analysis of NFHS-4 reported data freely available in public domain was done with the purpose to identify the differences in gender based data and to do the reason analysis with the purpose of suggesting remedies to address the issues of gender equity. All the results were seen dichotomously as for males and females to understand the extent of gender differences and identify the cause if any. The results of the analysis were eye opening as seen from the lens of Gender equity. These are the baseline data from where we have to head to targets of SDG 5 and understanding them in depth is essential to be on track.

Keywords: Gender Equity, Gender inequality, NFHS-4, Uttar Pradesh, India, SDG-5

INTRODUCTION

The National Family Health Survey (NFHS), the fourth in series, provides information on population, health, and nutrition for India and each state and union territory. This survey has been conducted under the stewardship of the Ministry of Health and Family Welfare (MoHFW),

Government of India. MoHFW has designated the International Institute for Population Sciences (IIPS), Mumbai, as the nodal agency for these surveys. For the first time, NFHS-4 has provided district-level estimates for many important indicators. This has to be explored with new dimensions in order to identify the cause for corrective action. The most populous state of India is not doing well in many indicators and understanding them from different perspectives is imperative for translational changes in the future. Poor performing States have to be the focus to target improvement and attainment of the SDG -5. Gender equity is one of the social factors playing silently, unfortunately widening the gaps in the data at all levels. With this background this secondary analysis was planned to highlight the issues on gender differences evident in the survey and also aims to suggest measures to bridge the gaps. Secondary analysis of Health research data is necessary to be looked from different social perspective to understand the social determinants of health and also helps us in saving resources of conducting such large scale surveys again. We need to create specific evidence of the social problems highlighting their extent. They are needed for advocacy at all administrative and political level to achieve the bigger Goals. Sharing of such evidence will also attract

global solutions to our problems. Being a developing Country our outlook shall be always be affirmative because whatever we are facing has been overcome by others, we just need to pick the right solution. Moving together in collaboration is the primary requirement for achieving SDGs.

MATERIALS & METHODS

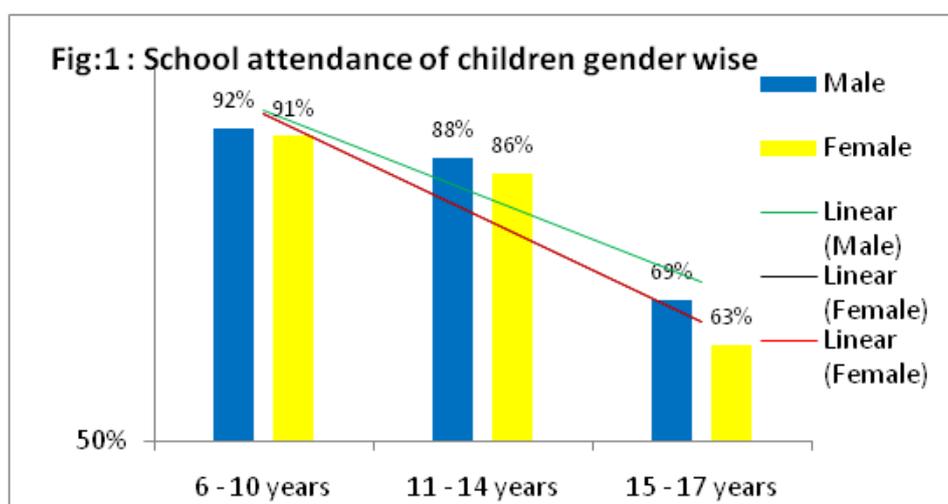
The secondary analysis of NFHS-4 reported data available in public domain, was done with the purpose to identify the differences in gender based data and to do the reason analysis with the purpose of suggesting remedies to address the issues of gender equity. Original data was collected with the help of interviews and questionnaires on wide range of variables from socioeconomic characteristics to health behaviour, health related events, states, services and also measurements of height, weight and haemoglobin. All districts of the state were included for data collection. Information was collected from 76,233 households, 97,661 women age 15-49 years and 13,835 men age 15-54 years. We have selected the gender specific data available for equity perspective analysis. Being a type of secondary data analysis, there is no intervention; therefore ethical clearance and informed consent were not required.

RESULTS AND DISCUSSION

Education, literacy and media exposure:-

The first data with gender wise comparison was of school attendance of children. Here the percentage of children attending school in Uttar Pradesh shows a linear decreasing trend across the increased age groups from 91.5% → 86% → 63% in the 15-17 years group (Fig.1). This shows a very high dropout rate of 25.5%. Looking at the gender perspective the difference follows a similar trend. In all three age groups the differences in male and female are increasing. In the 15-17 years age group only 63 % of girls are going to school with 69 % of boys i.e. 6% of the difference could be due to gender based issues and needs to be focussed. Despite several schemes to promote girl child education, the percentage of girls out of school (age 11-14) in Uttar Pradesh was found to be 9.9%, the highest in the country.

The operational definition of literacy used here was a person who has either completed standard six or passed a simple literacy test conducted as part of the survey. The women were behind the men by a larger gap of about 21%.



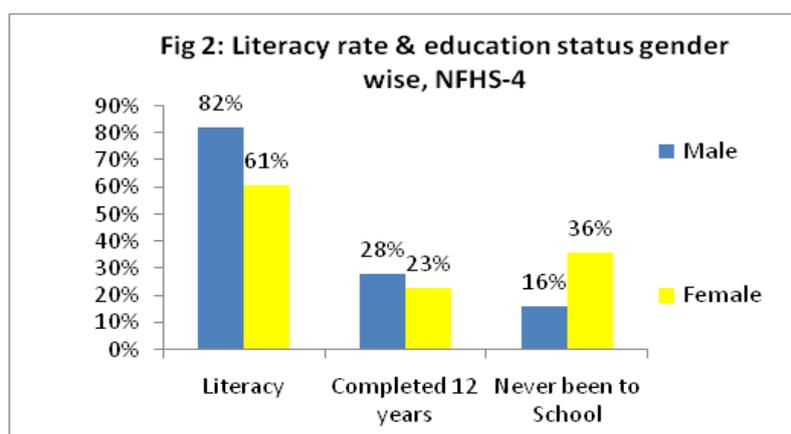
As there were only 61% literate women against 82% of men in age 15-49 years (Fig : 2). After the literacy rate the

data of schooling was compared, where only 23% of women aged 15-49 years have completed at least 12 or more years of

schooling in comparison to 28% of men. The never been to school percentage was also 36% of women and 16% of men. The social effect of education is clearly seen here as the women are not doing well in all three indicators related to their education and schooling. This information is crucial in planning targeted interventions & IEC strategies for *Women Empowerment* and Gender equity in such population. In the current age of communication apart from school education the social media and print media are also important in delivering the key messages to our population. Electronic media exposure was also seen to be lower

among women 50% than amongst men (60%) in Uttar Pradesh(Fig: 3).

This could be due to their low exposure and lesser use of gadgets as compared to Men. Men (49%) are much more likely than women (19%) to read a newspaper or magazine at least once a week. This could be attributed to their schooling status. Also 44 % of women and 27% of men and are not regularly exposed to print media or other forms of media. Gender equity cannot be established without increasing the awareness of the population, which is dependent on information.

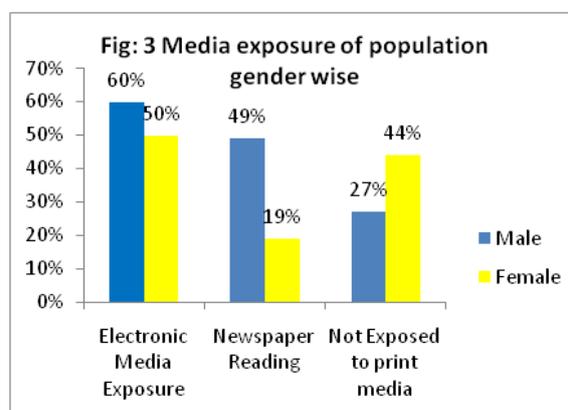


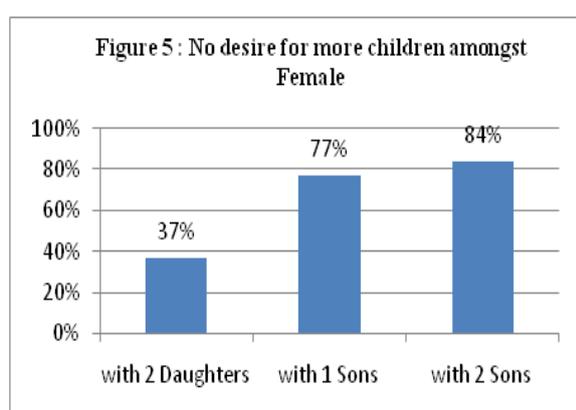
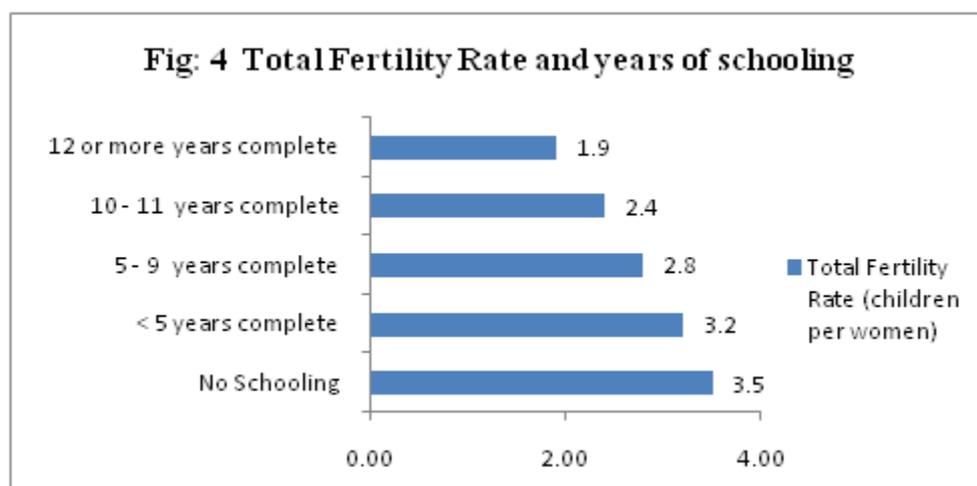
Women and Maternal Health:

Women were better in getting married at the legal age(Fig: 4). As only 21.1% of women age 20-24 years got married before the legal minimum age of 18 years, as compared to 28.7% of Men age 25-49 who got married before age of 21 years.

Among young women age 15-19 years in Uttar Pradesh, 4 per cent have already begun childbearing that is they have already had a live birth or are pregnant with their first child. Young women age 15-19 years who had no schooling are more than three times as likely to have begun childbearing (10%) as young women with 12 or more years of schooling(3%).The social impact of female education is clearly evident from the figure as we can see the TFR is inversely related to completed year of schooling of female child. It is 3.5 in

women with no schooling and reaches the target level of 1.9 for those who completed at least 12 years of schooling. This is also to realize here that we need inputs in female child education to control the population. Family planning services alone cannot give the returns required.





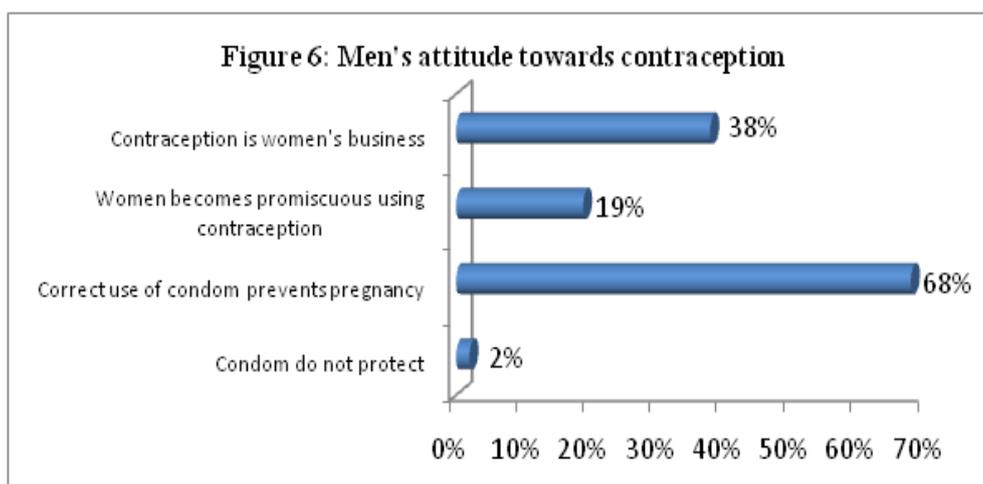
The Gender Biasness vs. Gender Equity: Issues in the Family Health due to Gender

In Uttar Pradesh, there is a strong preference for sons. About 31% women and 28% men want more sons than daughters, but only 1% women and 2% of men want more daughters than sons. This preference has to be addressed at the community level by education and awareness. Women's desire for more children is strongly affected by their current number of sons as seen in Figure 5. Among women with two children, 84 % with two sons and 77% with one son want no more children, compared with 37 % women with two daughters who want no more children. Notably, however the proportion of married women with two children who want no more children irrespective of their number of sons was found to be 73% for men it was also

similarly 73%. In Uttar Pradesh, unplanned pregnancies are relatively common. If all women were to have only the number of children they wanted, the total fertility rate would have reached their placement level of 2.1 children per woman, instead of the current level of 2.7 children per woman. What we have to realize here is that these figures are the result of tremendous work and expenditure being done for population control and Maternal & Child health care services.

Men's attitudes and their involvement in maternal care:

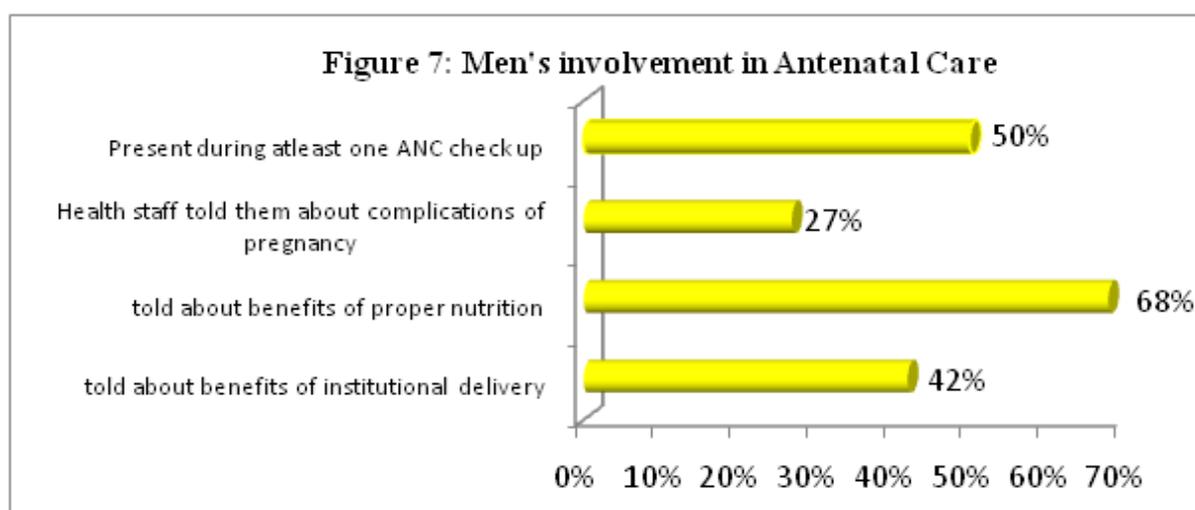
Almost two-fifths (38%) of men age 15-49 in Uttar Pradesh agree that contraception is women's business and a man should not have to worry about it (Fig : 6). However, only 19 per cent think that women using contraception may become promiscuous. A large majority of men (68%) know that a condom, if used correctly, protects against pregnancy most of the time. Only 2 per cent of men report that condoms do not protect against pregnancy at all. Contraception and family control is a mutual responsibility of the couple and we need to stress on it rather than shifting the onus from female to male. These behaviours have to be changed as we target the equity.



About 73% of men with a child under three years of age said that the youngest child's mother received antenatal care. Half of men with a child under three years said they were present during at least one antenatal check received by the child's mother (63% in urban areas and 46% in rural areas), but only 27 % were told by a health provider what to do if the mother had a pregnancy complication. This means that the health system is also giving the onus to the female and we cannot expect any handsome changes in male involvement without significant effort on the provider side.

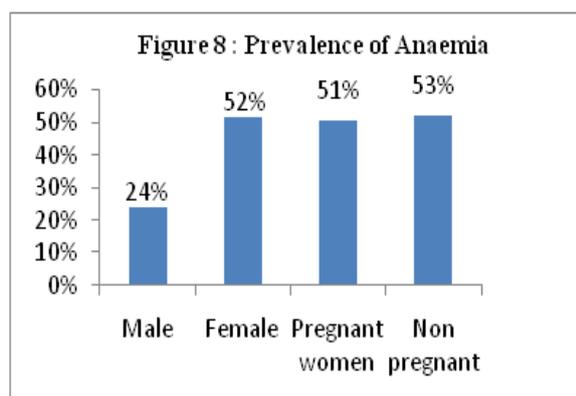
Only 34% of men were told about the signs of specific pregnancy complications. Among fathers with a child

less than three years of age, 46% was given information about various aspects of maternal care. 46% were also told about the importance of proper nutrition for the mother during pregnancy and 42 % were told about the importance of delivering the baby in a health facility (Fig: 7). 35% were told about family planning or delaying the next child by a health provider. Only 32% of fathers whose child was not delivered in a health facility were told about the importance of cord care, the importance of keeping the baby warm immediately after birth, and the importance of breastfeeding the baby immediately after delivery. This relevant information should be given compulsorily to the male partners to understand their role and responsibilities.



Health profile of the population: Focus on gender based variations in diseases and risk factors

Anaemia: It is a condition marked by low levels of haemoglobin in the blood. It not only causes weakness but also effects scholastic achievement and maternal and child health. Among children between the ages of 6 and 59 months, a large majority (63%) are anaemic. This includes 26 % per cent who are mildly anaemic, 34 % who are moderately anaemic, and 2% who suffer from severe anaemia. There was no difference in the prevalence of anaemia among girls and boys. In the adults 52% women in Uttar Pradesh have anaemia, including 39% with mild anaemia, 13% with moderate anaemia, and only 1% with severe anaemia. Slightly less than one-fourth of men (24%) are anaemic (Fig: 8).



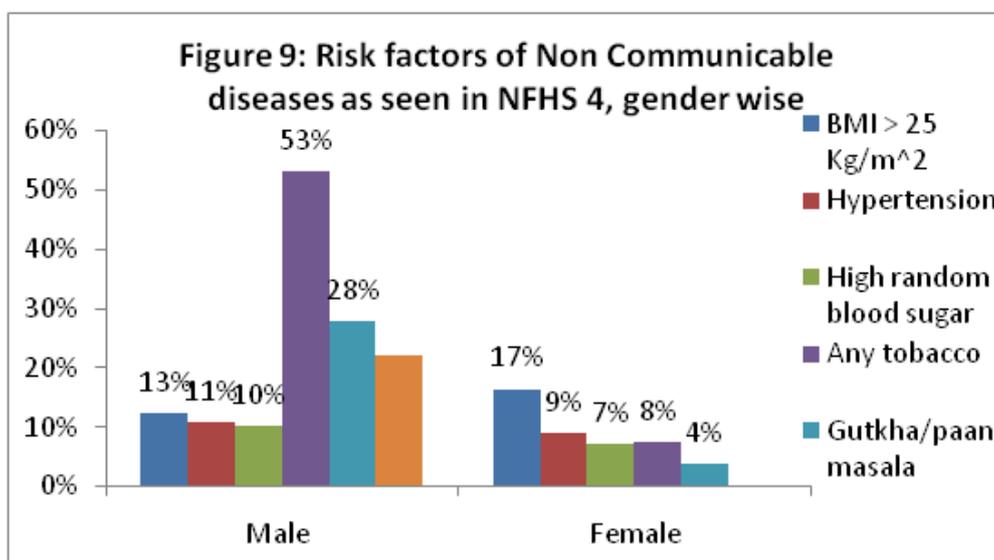
So conclusively females are at more risk than males for anaemia. The prevalence of medically treated tuberculosis is higher among men (411/100,000) than among women (261) and is higher in rural areas (353) than in urban areas (289). This may be attributed to more exposure to outdoor environment. According to self-reports, 996 women and 1,061 men age 15-49 per 100,000 have diabetes. Overall, 1,179 women and 963 men per 100,000 suffer from asthma.

Males are suffering more from Diabetes and Tuberculosis, and Females more from Asthma and Anaemia. The

prevalence of asthma among women and men is higher among older age groups, those who have little or no schooling, and those in rural areas. Goitre or any other thyroid disorder is slightly more common than asthma among women, but far less common than asthma among men (1,256 cases per 100,000 women and 287 cases per 100,000 men). The prevalence of any heart disease is more than twice as high among women (1,433 per 100,000) as among men (648 per 100,000). Among the five diseases, cancer is the least common, with 72 women per 100,000 and 79 men per 100,000 reportedly suffering from cancer. This should be utilized for specific preventive strategies at the program level.

Risk factors: Gender differences

The NCD (Non communicable diseases) epidemic has already hit the developing nations and risk factor mitigation has been proven as the most economical solution. Women have more abnormal BMI (body mass index > 25 is a risk factor) than men 16.5% vs. 12.5% respectively as seen in Fig: 9. About 9% of women and 11% of men age 15-49 years have hypertension. In measurement of random blood glucose, 7% women and 10% men had high blood glucose level. Older women and men, and women with no schooling, have relatively high blood glucose levels. 53% of men, but only 7.6% of women use some form of tobacco. Women (4%) and men (28%) are more likely to use *gutkha* or *paan masala* with tobacco than to use any other type of tobacco. Men are less likely to drink alcohol (22%) than to use tobacco, and almost no women 0.2% say that they drink alcohol. The women have lower prevalence of all the risk factors except BMI, which is best predictor, hence specific physical activity programs need to be strategically planned at all village and urban ward level.



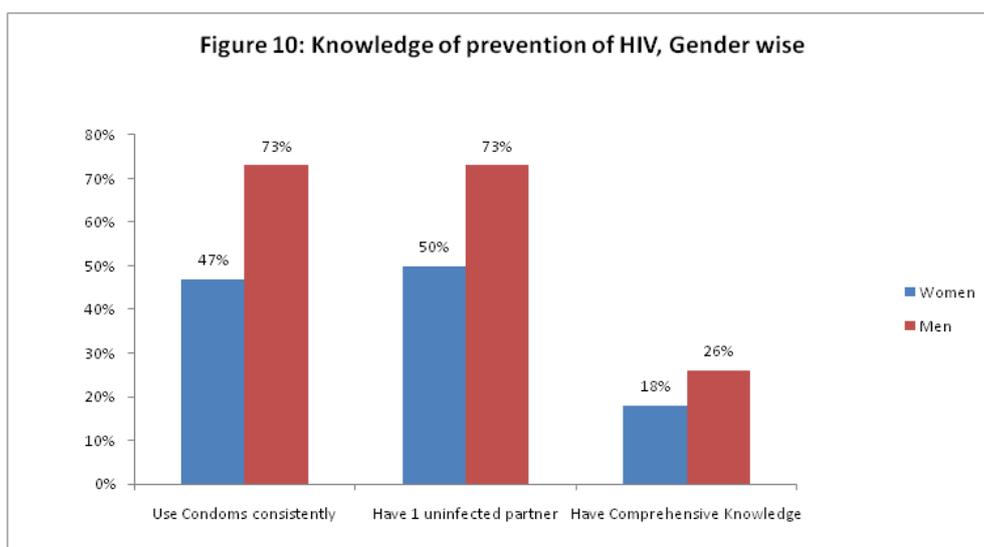
Awareness of HIV or AIDS:

61% of women in Uttar Pradesh have heard of HIV or AIDS. Men are more likely than women to know about HIV or AIDS. Over four-fifths of men (84%) have heard of it.

Knowledge of prevention and transmission:

Men are more likely than women to know how HIV is transmitted and how to keep from getting it. As only 47% of women know that consistent condom use can help prevent HIV/AIDS, compared with 73% of men, and only 50% of women know that having just one uninfected partner who has no other partners can reduce the chance

of getting HIV/AIDS, compared with 73% of men (Fig: 10). Only 18 % of women and 26 % of men in Uttar Pradesh have ‘comprehensive knowledge’ about HIV/AIDS. This means they know that consistent use of condoms every time they have sex and having just one uninfected sex partner who has no other partners can reduce the chance of getting HIV/AIDS, they know that a healthy-looking person can have HIV/AIDS, and they reject two common misconceptions about transmission or prevention of HIV/AIDS. Female education again appears to be the crucial factor in prevention of deadly epidemics of HIV, as knowledge is the key to success.

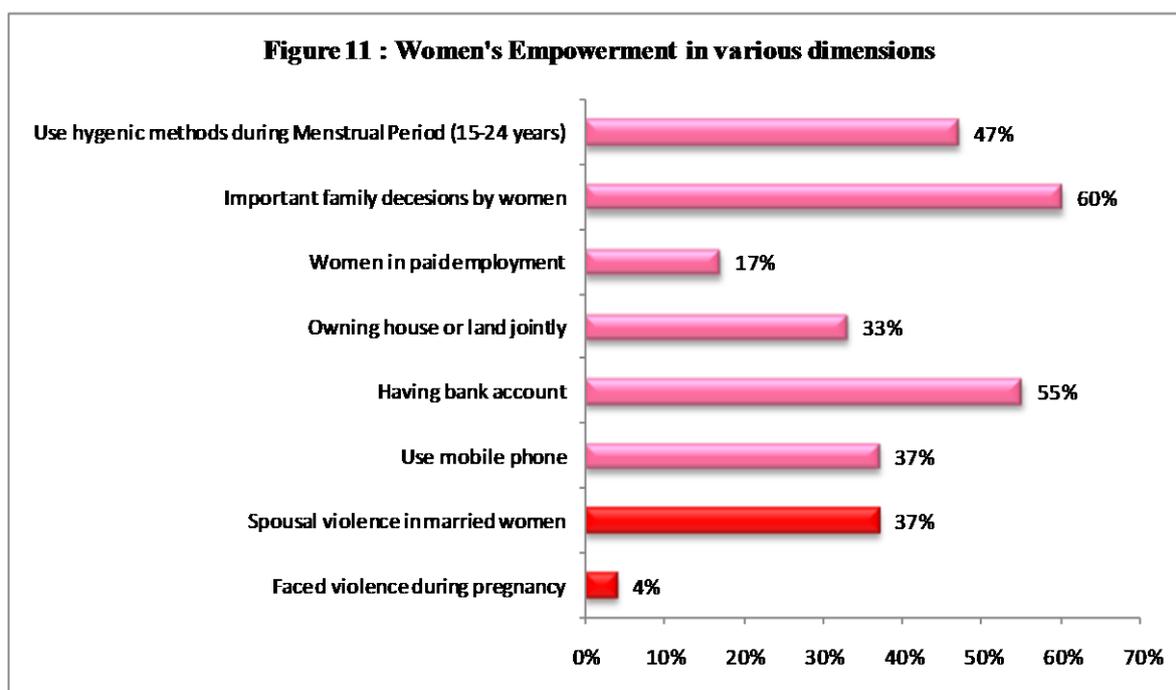


Higher-risk behaviour: This was reported by 1% percent of women and 9% of men during the past 12 months. Even fewer respondents said that they had multiple sex partners in the past 12 months (0.3% of women and 3% of men). We see large difference in behaviour gender wise but reporting bias cannot be ruled out. As only 1% men said they had paid for sex in the past year, these sensitive questions are subject to reporting bias, hence to be interpreted with caution.

Women's empowerment in Uttar Pradesh: Many important issues like women hygiene, employment and decision making has been taken in NFHS, which shall be the baseline for us to work in the direction of achieving Sustainable development goals 2030.

Women's hygiene:

Using a hygienic method of menstrual protection is important for women's health and personal hygiene. In NFHS-4, young women age 15-24 were asked what method or methods they use for menstrual protection, if anything. As it was a multiple response question about (81%) use cloth, 33 per cent use sanitary napkins, 14 per cent use locally prepared napkins, and 2 per cent use tampons. Overall, 47.1% of women use a hygienic method of menstrual protection (Fig: 11). Women with at least 12 years of schooling are more than three times as likely to be using a hygienic method as women with no schooling. Notably, only 40 per cent of rural women use a hygienic method of menstrual protection, compared with 69 per cent of urban women.



Employment and earnings: Only 25% of women were employed in the 12 months preceding the survey as compared to 79% of men. Among employed women, only 16.6 % earned cash, others were paid in kind or were not paid at all. Women reservation in all sectors should be the answer for such unjustified differences, from Parliament to villages the women representation shall be

at least 50% to address multiple issues faced by the women.

Decision making: Currently married women were asked who makes decisions about their own health care, major household purchases, and visits to their own family or relatives. Women are somewhat more likely to participate in decisions about their own health care (73%) than in

decisions about major household purchases and visits to their own family and relatives (69-71%). Overall, 60% of currently married women participate in making all three of these decisions, and 18 percent do not participate in making any of the three decisions.

Other indicators of women’s empowerment:

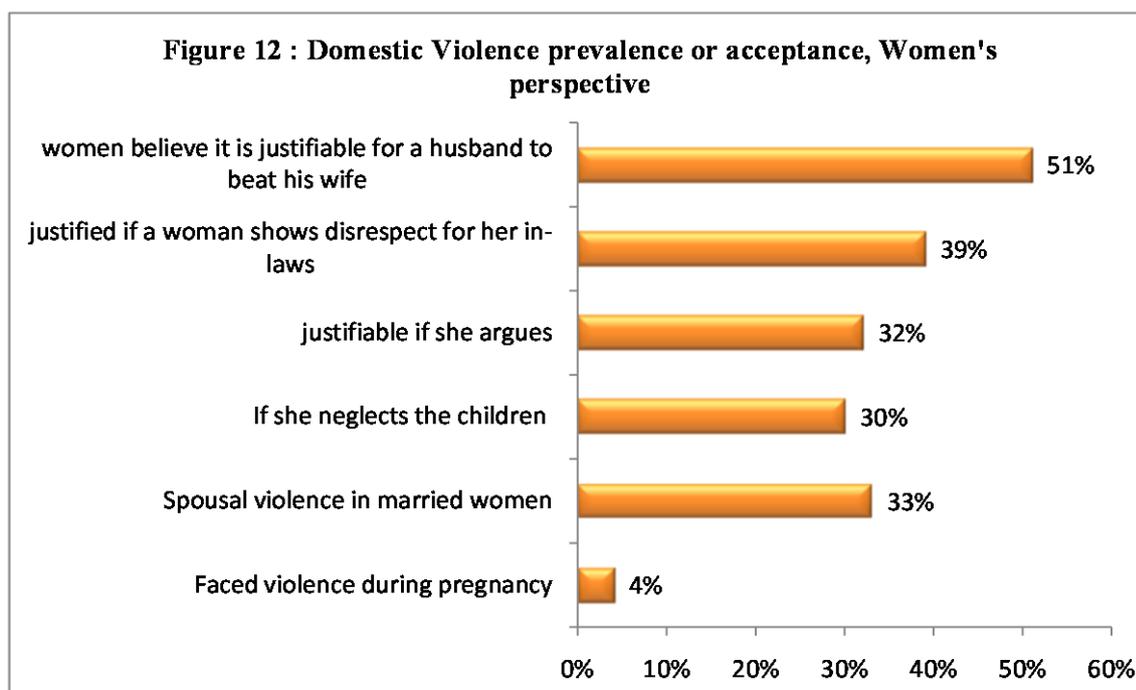
Majority of women 55% have a bank or savings account that they themselves use. This percentage is highest, at 73%, among women who have 12 or more years of schooling. Women’s knowledge and use of microcredit programmes is very limited. Only 28% of women know of a microcredit programme in the area and only 2% have ever taken a loan from a microcredit programme. Only 32% of women are allowed to go by themselves to all three of the following places: the market, a health facility, and places outside the village/community. Nearly one third 33% of women and 62% of men age 15-49 own a house alone or jointly with someone else. These are the indicators of social security and only educated women are a little

privileged in getting these. The numbers are indicative of our social restrictions and education level of women.

A little less than two-fifths (37%) of women have a mobile phone that they themselves use, and among women who have a mobile phone that they themselves use, 60% can read SMS messages. 49% of urban women have a mobile phone they themselves can use, compared with 33% of rural women. The proportion of women who have a mobile phone that they themselves use was found to be increasing with women’s schooling.

Gender-role attitudes & domestic violence:

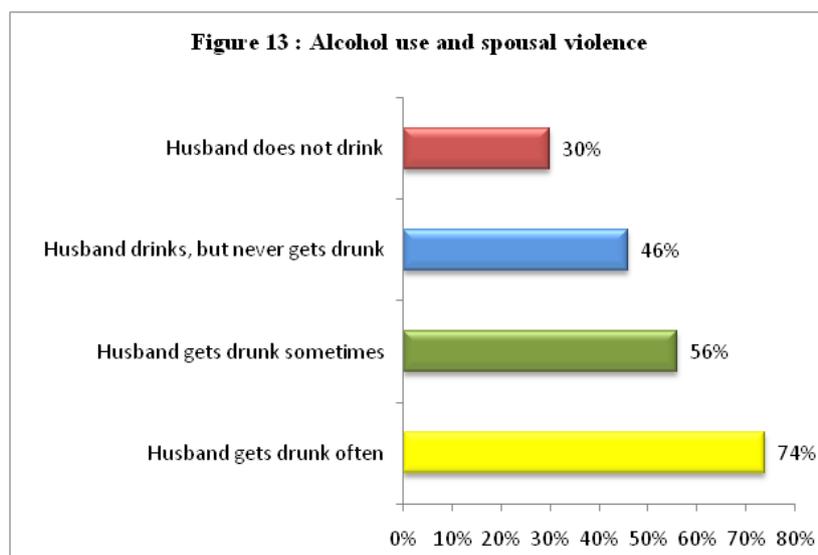
Our society has well adapted to the domestic violence and the astonishing responses of the Indian women are below. 51% of women believe it is justifiable for a husband to beat his wife under some circumstances (Fig: 12). Women are most likely to believe that wife-beating is justified if a woman shows disrespect for her in-laws (39%), followed by if she argues with him (32%), and if she neglects the house or children (30%).



Men are less likely to agree: 42% say that wife beating is justified in some circumstances, especially if the wife shows disrespect for in-laws (28%), if she argues with him (24%), or if he suspects her of being unfaithful (23%). Whatsoever justifications are given domestic violence can never be a part of civilised society, and we are here to address the issues of EQUITY, which looks way ahead from this reality. Even among women and men who have completed at least 12 years of schooling, 40% of women and 31% of men say that a husband is justified in beating his wife for one or more of the specified reasons.

Spousal violence: 33% per cent of ever-married women report having been slapped by their husband; between 11-17% per cent report being pushed, shaken, or having something thrown at them; having their arm twisted or hair pulled; being punched; or being kicked, dragged, or beaten up; and 2 % have been choked or burned on purpose, while 1 % have been threatened or attacked with a knife, gun, or other weapon. 6% report that their husbands have physically forced them to have sex and 4% report that their husband forced them with threats or other ways to perform sexual acts they did not want to perform. Overall, 37% of ever-married women have experienced spousal physical or sexual violence from their

current husband or, if not currently married, from their most recent husband. 14% report spousal emotional violence. Few ever-married women (2%) have ever initiated violence against their husband. About 4% pregnant women have ever experienced physical violence during one or more of their pregnancies. Although the prevalence of spousal violence is lower among more educated women, 1 in 5 Women who have at least 12 years of schooling have experienced physical or sexual spousal violence. The contextual and intergenerational aspects of spousal violence are clear from the fact that women whose mothers were beaten by their fathers are almost twice as likely to be in abusive marriages themselves. Women whose husbands consume alcohol are much more likely than women whose husbands do not consume alcohol to experience spousal violence, especially if the husband often gets drunk. However, 30% of women whose husbands do not drink alcohol have experienced physical or sexual spousal violence (Fig: 13). Almost one-fifth (26%) of women who have experienced spousal physical or sexual violence have suffered injuries as a result of the violence, and among women who have experienced both physical and sexual violence this proportion rises to 53%. The most common type of injury is cuts, bruises, or aches.



Help seeking: Only 15% of women who have ever experienced physical or sexual violence by anyone have sought help. Here nearly four-fifths (77%) of women have neither sought help nor told anyone about the violence. Abused women who have sought help most often seek help from their own families. Only 4 per cent of abused women who sought help for the violence sought help from the police. This are the areas of concern that the women should be able to ask for help otherwise the reported data must be much lower than the actual and we may not adequately address the issues of equity.

SUMMARY & CONCLUSION

The gender equity has to be addressed at the primordial level rather than secondary. We have to work together at the level of primary education and primary care to target the equity issues. Special attention has to be given to school dropouts and that too female. Complete education will itself result in better health, better family health and a Nation with equal opportunities for both the gender. Then it is up to an individual to choose the role he or she likes accordingly. This type of analysis and representation will have exponential effects and will ignite the technical minds to work up for the suffering India.

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REFERENCES

1. International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), India, 2015-16: Uttar Pradesh. Mumbai: IIPS.
2. Thorne, S. (1990) 'Secondary Analysis in Qualitative Research: issues and implications' in Morse, J.M. (Ed.) Critical Issues in Qualitative Research Methods. London: Sage
3. Dobe M, Taklikar C S. Health Inequalities in India – Will Looking through The Social Determinants Lens, Make A Difference? J Comprehensive Health 2019;7(2): 6-11
4. Sunita Kishor and Kamla Gupta. 2009. Gender Equality and Women's Empowerment in India. National Family Health Survey (NFHS-3), India, 2005-06. Mumbai: International Institute for Population Sciences; Calverton, Maryland, USA: ICF Macro.
5. Gita Sen, Piroska Östlin, Asha George. Unequal, Unfair, Ineffective and Inefficient - Gender Inequity in Health: Why it exists and how we can change it - Report of the Women and Gender Equity Knowledge Network of the Commission on Social Determinants of Health 2007.
6. Dr Jessica Allen, Dr Flavia Sesti. Health inequalities and women – addressing unmet needs. British Medical Association
7. Sharma, P. P., Kumar, A., & Singh, P. (2010). A study of gender differentials in the prevalence of tuberculosis based on NFHS-2 and NFHS-3 data. Indian journal of community medicine : official publication of Indian Association of Preventive & Social Medicine, 35(2), 230–237. <https://doi.org/10.4103/0970-0218.66869>
8. Sandra L. Martin, Amy Ong Tsui, Kuhu Maitra, Ruth Marinshaw. Domestic Violence in Northern India. American Journal of Epidemiology. 1999. Vol. 150, No. 4
9. Hannah F.G. Taukobong. Does addressing gender inequalities and empowering women and girls improve health and development programme outcomes? Health Policy and Planning, 31, 2016, 1492–1514
10. Reena Patel. The Persistence of Traditional Gender Roles in the Information Technology Sector: A Study of Female Engineers in India. Information Technologies and International Development. Volume 2, Number 3, Spring 2005, 29–46
11. Radha R. Sharma. Opening the gender diversity blackbox : causality of perceived gender equity and locus of control and mediation of work engagement in employee well-being. Hypothesis and theory: 09 October 2015. doi: 10.3389/fpsyg.2015.01371
12. Sophie Witter. Minding the gaps: health financing, universal health coverage and gender. Health Policy and Planning, 32, 2017, v4–v12 doi: 10.1093/heapol/czx063
13. Kelly W Muraya. 'Gender is not even a side issue it's a non-issue': career trajectories and experiences from the perspective of male and female healthcare managers in

- Kenya. Health Policy and Planning, 34, 2019, 249–256doi: 10.1093/heapol/czz019
14. Abhishek Kumar, Aditya Singh. Explaining the gap in the use of maternal healthcare services between social groups in India. Journal of Public Health | Vol. 38, No. 4, pp. 771–781 | doi:10.1093/pubmed/fdv142. December 11, 2015
15. SaktiGolder, Measurement of Domestic Violence in NFHS Surveys and Some Evidence. Oxfam India Report on NFHS 3 and 4 comparison.

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