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Health and Women Empowerment: An Analysis of Tripura

Dr. Sanjay Sinha, Assistant Professor
Department of Economics, Patharkandi College, Patherkandi, Karimganj, Assam

Abstract

This paper attempts to analyse the status of women empowerment and health of Tripura by taking data and references from different Government Reports like HDR Government of Tripura, NFHS-3, NFHS-4 etc. The dimensions covered in this paper are Participation of women in household decision making, mean ages at marriage and Maternal care indicators. It has been found that out of all discussed dimension in few Tripura recorded good progress and in some other aspect it has to take corrective actions.

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Key Words: Empowerment, Health, Decision making, Mean ages at Marriage, Maternal Care.

Introduction:

Women are the prime targets of programmes that aim at improving maternal and child health and achieving other desired demographic goals. This is not surprising since women are the ones that bear children and are typically the primary caregivers in households. An understanding of the status and empowerment of women in society and within their households is thus critical to promoting change in reproductive attitudes and behaviour, especially in patriarchal societies (Dyson and Moore, 1983; Jejeebhoy, 1995; Jeffery and Basu, 1996; Kabeer, 2001). Notably, the National Population Policy 2000, specifically identified the low status of women in India as an important barrier to the achievement of population and maternal and child welfare goals (Ministry of Health and Family Welfare, 2000).

Results of several studies have shown that for a long time, women's health has been viewed within a narrow perspective of their child- bearing and reproductive role. In the studies done so far on women's health there was a tendency to equate women's health with maternal health (Begum 1986; Khan 1988; Chen et al 1974; Chaudhury 1984; BARC 1990; GOB 1975, 1980, 1985, 1990). But, the issue of women's health takes on a new dimension following the phenomenal increase in women's participation in the labour force. However, this has been largely overlooked both by researchers and policy-makers.

The decades of the 1980s and the 1990s have been characterised by a variety of pressures on the government of India and state governments, especially from international bodies and from groups within for affirmative action in favour of women as well as incorporating gender issues in policy planning. One of the primary objectives of the Ninth Five-Year Plan (1997-2002) is to create an enabling environment 'where women can freely exercise their rights both within and outside home as equal partners along with men. The Ninth plan document further states that this will be realised through early finalisation and adoption of the 'National Policy for Empowerment of Women'.

The task of saving the lives of millions of women and female children throughout the world, who die every year from easily prevented illnesses, is daunting. The outrage provoked by so many needless deaths, however, can now be tempered by hope because demands for better health care and improved quality of life for all females are being voiced by communities, health personnel, researchers and policy makers.

In all societies economic policies, such as those that enslave women in low-wage jobs under dangerous conditions, and development strategies, like those that take land out of subsistence farming and put it into cash crops, have a profound effect on the health status of women and their families. Mothers, many of whom are single heads of households, are burdened not only with economic problems but also with the consequences of civil conflict and environmental degradation. They are often ignored by male-dominated health and social services delivery systems or denied equal access to services.

Even within the family disparities exist because of social and cultural bias. For example, preference for the son can lead to the daughter's being given less food. The girl child is also expected to do more work and has less access to education and medical care than the boy. Consequently girls are often ill-prepared to marry and bear children, which they do before they are physically, psychologically and financially equipped to take on the responsibility. Often premature marriage begins a vicious cycle of malnutrition, where underweight mothers have underweight babies who are at risk of suffering from nutritional and educational deprivations. The problems facing women and girl children need, then, to be tackled at all levels: in the family, in the community, and in society at large.

State Profile

The State of Tripura has an area of 10,491.69 sq km having 856 kms of international border with Bangladesh, 109 kms long border with Mizoram and 53 kms border with Assam. Around two-thirds of the State of Tripura has an area of 10,491.69 sq km having 856 kms of international border with state is hilly with six major hills running in the North-South direction. The hilly terrain makes a large area of the State difficult to access and this has implications on the accessibility of the people to formal health care.

Demographics

Tripura is the second most populous state in North-East India, after Assam. According to the census of 2011, Tripura has a total population of 3,671,032 with 1,871,867 males and 1, 77,165 females, the sex ratio of the state is 961 females per thousand males. The density of population is 350 persons per square kilometre. Tripura constitutes 0.3% of India's total population. In the 2001 census of India, Bengalis represent almost 70% of Tripura's population and the native tribal populations represent 30% of Tripura's population. The tribal population comprises several different tribes and ethnic groups with diverse languages and cultures with the largest tribal group being the Kokborok-speaking tribes of the Tripuri (16% of the state's population), the Jamatia, the Reang, and the Noatia tribal

communities. There is some tension between these native tribal populations and Bengali settlers in tribal areas.

Tripura ranks 22nd in the human resource development index and 24th in the poverty index in India according to 1991 sources. The literacy rate of Tripura in 2011 was 87.75% which was higher than the national average of 74.04%.

Indicators of Women's Empowerment

Given the vast amount of data NFHS-3 provides, there are a very large number of alternative indicators that can be defined. In this paper we present the subset we believe best captures the different dimensions of women's empowerment in India. An important factor guiding the actual selection of indicators is that NFHS-3 and NFHS-2, as also NFHS-1, collected individual-level data only from ever-married women, the vast majority (94 per cent) of whom are currently married. Hence indicators selected are those that are most relevant to married women. A caveat also needs to be specified. There are many factors that are likely to influence women's empowerment levels, such as age and urban-rural residence that a complete analysis of empowerment should take into account. In presenting only aggregated data, there is no assumption that these factors are not important.

Indicators of evidence of empowerment: Two sets of indicators of evidence of empowerment are available in NFHS-3. The first set purports to measure women's degree of control over their environment by measuring their participation in household decision-making and their freedom of movement. The second set addresses women's attitudes with regard to gender equality. As mentioned above, an essential element of empowerment is the belief in the ideal of gender equality in roles and rights in society, as well as in the home. Thus, the second set of indicators explores women's acceptance of unequal gender roles by documenting their attitudes about the education of male and female children and by evaluating their preference for sons. In addition, indicators based on women's attitudes towards wife-beating, particularly, attitudes that see the beating of wives by husbands as justified, are indicative of women's acceptance of their lower status both absolutely and relative to men. While such attitudes do not necessarily signify approval of men beating their wives, they do signify women's acceptance of norms that give men the right, in this case, to discipline women with force.

Indicators of access to potential sources for empowerment: These indicators measure women's access to education, the media and meaningful employment. Education and media exposure can help to empower women by equipping them with the information and the means to function effectively, especially in the modern world. Employment, particularly for cash and in non-traditional occupations, potentially empowers women by providing financial independence, alternative sources of social identity, and exposure to power

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structures independent of kin networks[Dixon-Mueller 1993].In this category, we also include a variable that measures the extent to which household expenditure depends on women's earnings, on the grounds that women are likely to have greater access and control over resources if they are the primary earners in a household.

Indicators of the setting for empowerment: These indicators focus on the circumstances of women's lives and reflect the opportunities available to women. Important among these is the age at first marriage. An early age at first marriage is likely to have a negative effect on empowerment by virtually terminating women's access to sources of empowerment such as formal education [Mason 1986, 1987] and to the resources of their natal families, including in some cases their emotional support. Residence in non-nuclear families is likely to negatively affect women's ability to access resources directly and to exercise decision-making control [Dyson and Moore 1983; Dixon-Mueller 1989]. Further, large age and educational differences between the husband and wife can put the wife at a relative disadvantage with regard to her ability to exercise power within the marriage. Finally, NFHS-2 also provides data on women's experience of violence. Violence against women is a fundamental violation of women's rights. In addition, an environment in which women are under the threat of violence curtails women's ability to control, or even access, resources [Heise, Ellsberg and GoLtemoeller 1998].

Women's participation in decision making by state

Table I: Women's participation in decision making in the state.

Percentage of currently married women who usually make decisions on four specific kinds of decisions either by themselves or jointly with their husband, and percentage of men who say that wives should have an equal or greater say than their husband in specific kinds of decisions, in Tripura 2005-06								
State	Percentage of women who usually make specific decisions alone or jointly with their husband						Percentage of men who say that wives should have the final say alone or jointly with their husband in:	
SL.	Own health care	Making major household purchases	Making purchases for daily household needs	Visits to her family or relatives	Percentage who participate in all four decisions	Percentage who participate in none of the four decisions	All of the five decisions1	None of the five decisions1
Tripura	59.7	48.1	56.9	60.4	30.2	18.9	22.8	1.0
Meghalaya	87.5	82.5	84.1	87.3	77.3	9.3	69.8	10.5
Jammu & Kashmir	43.5	44.7	46.9	43.4	25.2	37.3	55.6	5.2
India	62.2	52.9	60.1	60.5	36.7	20.5	49.7	3.6

Source: NFHS-3

Table 1 provides information by state on currently married women's participation inthe four decisions women were asked about and currently married men's opinion with regard

to a wife having an equal or greater say in the five decisions men were asked about. The proportion of currently married women who participate in all four decisions varies from a high of 77 percent in Meghalaya and 30.2 percent in Tripura to a low of 25 percent in Jammu and Kashmir compared to 36.7 percent in all India. In fact, in NE region only in Tripura less than half of currently married women say that they participate in all four decisions. According to decision, the proportions participating range from 44 percent in Jammu and Kashmir to 87.5 percent in Meghalaya and 59.7 percent for decisions about own health care, from 48.1 percent in Tripura to 83 percent in Meghalaya for decisions about making major household purchases, from 47 percent in Jammu and Kashmir to 57 percent in Tripura for decisions about making purchases for daily household needs, and from 43 percent in Jammu and Kashmir to 87.3 percent in Meghalaya for decisions about visits to her family or relatives.

In the country as a whole, 53 percent of currently married women participate in decisionsabout making major household purchases and 60-62 percent participates in each of the remaining three decisions. However, women's pattern of participation by decision varies greatly by state. Overall, there are 11 states where women are most likely to participate in decisions about their own health care, another 11 where they are most likely to participate in decisions about visits to their family or relatives, and seven where they are most likely to participate in decisions about making purchases for daily household needs. Women are least likely to participate in decisions about making major household purchases in the majority (24) of states, including all of the states in the East, West and Southern Regions of the country. There is no state in which women most often participate in decisions about major household purchases. Notably, in Chhattisgarh and Arunachal Pradesh, of all the decisions asked about, women are least likely to participate in decisions about their own health care.

The percentage of currently married men who say that, in a couple, a wife should have atleast equal say as her husband in all five decisions is highest in Haryana (81 percent) and lowest in Tripura (23 percent). Notably, while participation of women in decision making tends to be most common in several of the north-eastern states, men's approval of a wife's participation in decision making is relatively high in only two north-eastern states (Sikkim and Meghalaya) as well as in the northern states of Haryana, Punjab, Delhi, Himachal Pradesh, and Uttaranchal.

Women's Health

Table: 2 Mean ages at marriage

Year	1971	1981	1991	1993	1998-1999
Mean age at marriage	18.5	20.3	21	21.2	22

Source: HDR Tripura 2007

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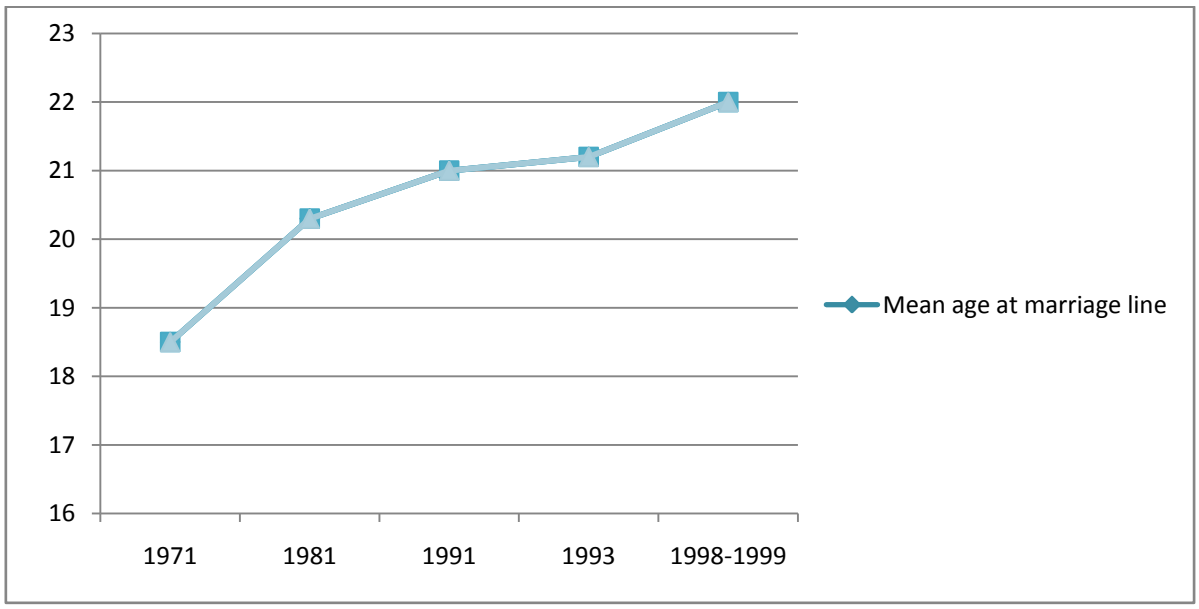
Figure: 1



Mean age at marriage is an important factor in determining women's health, particularly since it is an important factor in determining the age of first pregnancy. The mean age at marriage of women in Tripura (22 years in 1998– 99) was higher than the national figure (19.7 years). Comparative data suggest that the mean age at marriage of females has risen significantly, by about 4 to 5 years, since 1971. This improvement is related to enhancement in literacy rates both in urban as well as rural areas. Interestingly,the mean age at marriage is higher in rural areas than in urban areas, in contrast to the pattern at thenational level. This is an excellent outcome as the majority of the population lives in the rural areas.

According to NFHS-2 indicate that the State did better than the national average in respect of some aspects of ante-natal and post-partum care of mothers, particularly in the distribution of iron folic acid tablets (IFA) and syrup. Further, pregnant women of Tripura have a better chance of safe delivery, as almost 71 per cent of respondents reported receiving ante-natal checks from a health professional during pregnancy (NFHS-2 1998–99). During pregnancy, two tetanus taxied injections were received by 66 per cent of pregnant women.

Maternal Care Indicators in Tripura

Table 3 shows in five maternal care indicators for births. These indicators together summarize the extent to which the state has progressed toward achieving safe motherhood goals at all three stages of the birth process: antenatal, delivery, and postnatal. The first indicator is a summary antenatal care indicator which shows the percentage of last live births whose mothers had all of the following: three or more antenatal care visits (with the

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first visit within the first trimester of pregnancy), two or more tetanus toxic injections, and iron and folic acid tablets or syrup for three or more months. The next two indicators pertain to care during delivery and show the percentage of births delivered in medical institutions and deliveries assisted by health personnel. The last two indicators pertain to postnatal care for mothers and show the percentage of deliveries with a postpartum check-up within 42 days of the birth and within two days of birth.

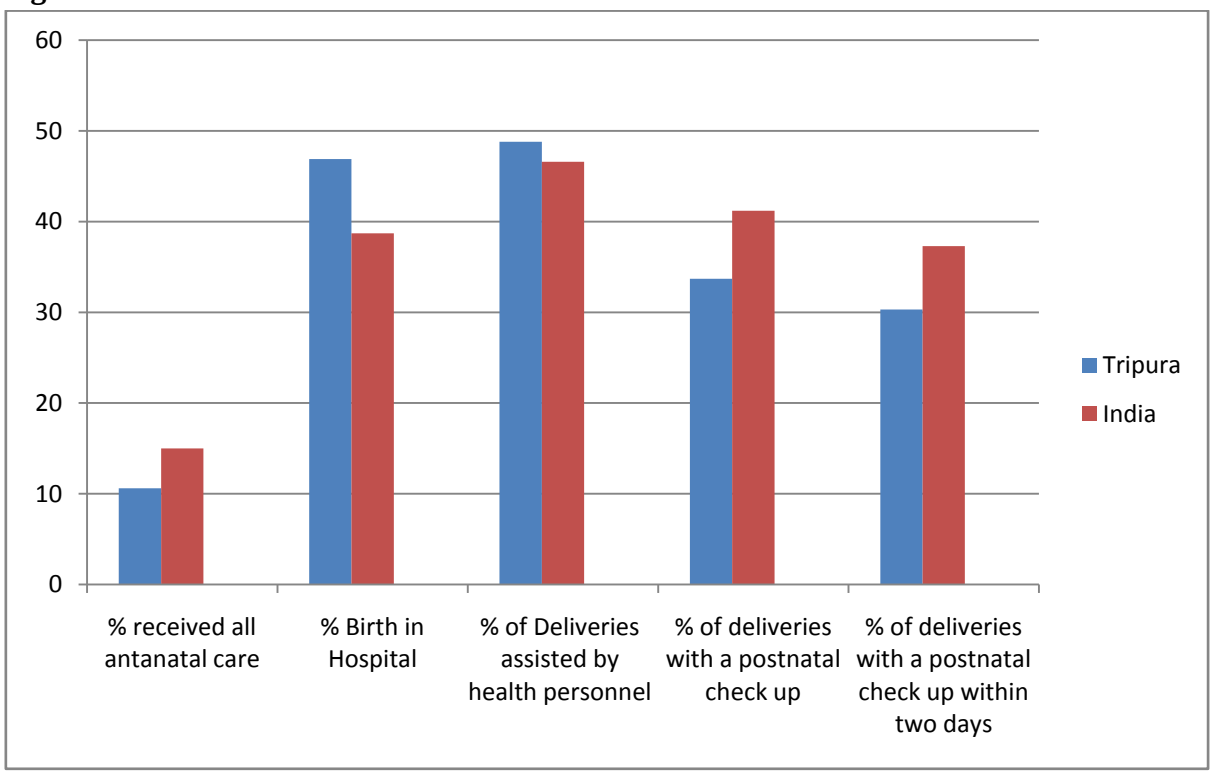
Table 3: Maternal care indicators in Tripura

Maternal care indicators for births during the five years preceding the survey by state, India, 2005-06

State	Percentage who received all recommended types of antenatal care	Percentage of births delivered in a health facility	Percentage of deliveries assisted by health personnel	Percentage of deliveries with a postnatal check-up	Percentage of deliveries with a postnatal check-up within two days of birth
Tripura	10.6	46.9	48.8	33.7	30.3
India	15.0	38.7	46.6	41.2	37.3

NFHS-3, 2005-06

Figure: 2



For India as a whole, mothers of only 15 percent of births received all of the required components of antenatal care this indicator shows 10.6 percent in Tripura. Whereas only

38.7 percent of births delivered in health institutions in all India level here good improvement have been made by Tripura by recording 46.9 percentbirths delivered in health institutions. Only 46.6 percent of deliveries are assisted by health professionals in India as against that in Tripura it is 48.8 percent. Percentage of deliveries with a postnatal check-up3 in India is 41.2 as against in Tripura the figure is 33.7. Percentage of deliveries with a postnatal check-up within two days of birth in India is 37.3 where in Tripura it is 30.3.

Conclusions

The women of developing countries bear a greater share of the cost than do their spouse**s.** It has been argued here that empowerment of women bestows the further benefit to society of increasing the incentives of parents to educate their children. The return on the education of children clearly increases with their survival probability, and this probability is higher when women are more empowered to make decisions within the household. To protect their greater investment in the education of their children, parents would be induced to invest even more in the healthcare of the children. This decline in the mortality rate of children would lead parents to curtail that part of their fertility which is meant for insurance purposes. Thus the empowerment of women emerges as potentially a very strong factor in hastening the demographic transition of a developing country. It has also been argued here that, for the empowerment of women to have entirely benign effects in developing countries, it must enable daughters also to provide old age assistance to parents, that is, daughters too must be rendered economically valuable to parents. If not, the fertility decline brought about by the greater bargaining power of women within the household may induce a greater discrimination in terms of healthcare expenditures against daughters - thereby trading off the survival prospects of daughters in favour of those of sons. Here an important point to remember in this context is the role of people's awareness about health. People conscious about their health may contribute significantly in generating informed collective demand for better health care services. The NGOs may play important role in this area.

References

1 Pratima Paul-Majumder, *"Health Impact of Women's Wage Employment: A Case Study of the Garment Industry of Bangladesh",*The Bangladesh Development Studies Vol. XXIV, March-June 1996. Nos. 1 & 2.

2. Shobhita Rajagopal and Kanchan Mathur*,"Women's Empowerment through State"* Economic and Political Weekly, Vol. 35, No. 33 (Aug. 12-18, 2000).

3. Sunita Kishor and Kamla Gupta, *"Women's Empowerment in India and Its States: Evidence from the NFHS-2",*Economic and Political Weekly, Vol. 39, No. 7 (Feb. 14-20, 2004)

4. Govt of India, NFHS-3 2005-6.

5. Govt. of Tripura, HDR TRIPURA 2007.

6.Govt of India, NFHS-2 1998-1999.