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Moving from Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs) for Achieving Inclusive Growth - A Study of Women Health Status in Rural India -

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Abstract:

In the UN General Assembly India presented the new targets under the SDGs, which has replaced the MDGs. India has set itself a challenging target to reduce MMR to 70 per 1000 live births and for neonatal and under – five to 12 and 25 per 1000 births respectively to be achieved over the next 15 years. Still India did not achieve 100 percent target set by the MDG 2015 especially for infant Mortality rate, Under-five mortality rate and MMR. Though India has made substantial progress in reducing infant and MMR over the last two decades, continues to lag Sri Lanka, Bangladesh and Nepal. The child immunization rate and total life expectancy of India is also lower than these countries.

As SDG 3 goal No. 3.7 India has planned to ensure universal access to sexual and reproductive health care services including for family planning, information and education and the integration of reproductive health into national strategies and programme by 2030. (SDG-NITI Aayog: 2016).

However, there are several reproductive health concerns in India, which need to address in order to improve reproductive health status of Married Adolescent Women.

In India, especially in rural part of India early marriage and adolescent pregnancy remains a common practice despite its illegality many studies highlighted that the practice of child marriage is very common in rural part of India. Only augmentation of age by law is not sufficient there is need to address and communicate the issues. Then only India can achieve the targets set for SDG3 goal 3.7

Without bringing improvement in women's reproductive health status no any country can achieve target set for the development in any field.

Keywords: MDG, SDG,

a) Rationale and Significance of the study

Introduction:

The MDGs that were launched in 2000 set 2015 as the target year. Recognizing the success of the Goals and the fact that a new development agenda was needed beyond 2015 countries agreed in 2012 at Rio+20, the UN Conference on Sustainable Development, to establish an open working group to develop a set of SDGs, have presented its recommendation for the 17 SDGs[1]

The goals are broad in scope, as they will address the interconnected elements of sustainable development: economic growth, social inclusion and environmental protection. The MDGs have focused only on social agenda.[1]

The MDGs targeted developing countries, mostly the poorest while the SDGs will apply to the entire world, the rich and the poor. The Goals and targets will stimulate action with 5Ps e.g. people, planet, prosperity, peace and partnership in areas of critical importance for humanity and the planet. On Sept.25th 2015, 193 world leaders and member states of the UN committed to 17 goals to achieve 3 extraordinary things in the next 15 years and reached consensus on the outcome document of the new agenda "Transforming our World: The 2030 Agenda for Sustainable Development". End extreme poverty. Fight inequality & injustice. Fix climate change.[1]

As on 1st March, 2011 India's population stood at 1.21 billion comprising of 623.72 million (51.54%) males and 586.46 million (48.46%) females. India, which accounts for world's 17.5 percent population, is the second most populous country in the world with over 1.271 billion people (2015), surpassing China(19.4%), projected to be the world's most populous country by 2025, more than a sixth of the world's population. In 1951, the population of India was around 381 million. In absolute terms, the population of India has increased by more than 181 million during the decade 2001-2011. Of the 121 crore Indians, 83.3 crore (68.84%) live in rural areas while 37.7 crore (31.16%) live in urban areas, as per the Census of India's 2011.

According to latest UN report with 356 million 10-24 year-olds, India has the world's largest youth population despite having a smaller population than China.[4]

India has more than 50% of its population below the age of 25 and more than 65% below the age of 35. It is expected that, in 2020, the average age of an Indian will be 29 years, compared to 37 for China and 48 for Japan; and, by 2030, India's dependency ratio should be just over 0.4.[4]

The sex ratio in post-independence (Number of females per 1000 males) in India had recorded decline till 1991. Sex ratio in India has since shown some improvement. It has gone up from 927 females per 1000 males in 1991 census to 933 females per 1000 males in 2001 census and to 940 females per 1000 males in 2011 Census of India.

The prospects of health care in India in 2020, an optimistic scenario will be premised on an average 8% rate of economic growth during this decade and 10% per annum thereafter- If so, what would be the major fall out in terms of results on the health scene. In China in 2000 had a life- expectancy at birth of 69 years (M) and

73(F) whereas India had respectively 60 (M) and 63 (F). More importantly, healthy life expectancy at birth in China was estimated in the World Health Report 2001 at 61 (M) and 63.3 (F) whereas in Indian figures were 53 (M) and 51.7 (F). If we look at the percentage of life expectancy years lost as a result of the disease burden and effectiveness of health care systems, Chinese men would have lost 11.6 years against Indian men losing 12.7 years. The corresponding figures are 13.2 for Chinese women and 17.5 for Indian women. Clearly, an integrated approach is necessary to deal with avoidable mortality and morbidity and preventive steps in public health are needed to bridge the gaps, especially in regard to the Indian women. Taking all the factors into consideration, longevity estimates around 20-25 could be around 70 years, perhaps, without any distinction between men and women.

There are data released by various organizations shows that due to illiteracy among women, unnecessary hysterectomies were being performed in Indian private hospitals and exploit poor women economically as well as government-run insurance schemes. Doctors telling them that it might be a cancer or a hole or a stone in the uterus without doing any thorough necessary investigations. However Dr Shah, former president of FOGSI said that modern medicines could fix 95% of woman's menstrual problems without the need for surgery.

As per Oxfam's local NGOs in the Dausa district of Rajasthan showed that 258 out of 285 women 65% investigated over six months had undergone hysterectomies. Many of these women were under 30, with the youngest being 18 years old. The various NGOs released their study findings that the similar circumstances happening in Maharashtra and their neighboring states[10].

In India most adolescent girls 15-19 years old are married. By the age of 18 years,

According to WHO, in 2010 every day about 800 women die due to complications of pregnancy and childbirth. Reproductive and sexual ill-health accounts for 20% of the global burden for women and 14% for men.

Of great concern is the persistent level of malnutrition with over 40% of children and 36% of adults women classified as undernourished.

The reasons for such high levels of malnutrition and anemia are complex. They include poverty, gender inequity, specific dietary patterns and recurrent illness, all these acting in conjunction. Patriarchy and gender discrimination contribute to malnutrition levels by early age of marriage and birth of the first child, reduced access to nutrition during critical periods like pregnancy, lactation, adolescence and the first five years of life, and less access to education and health care. Keeping girls in schools till they complete adolescence could be one of the most effective health measures.

54% women are married. 25-35% of adolescent girls of India begin child bearing as early as 17 years. The age at marriage for women has undergone a secular increase, the reality is that more than two-fifths of all women aged 20–24 were married by 18 years and 16 percent of all girls aged 15–19 have already experienced pregnancy or motherhood.

Women in India generally have less political representation and less education than men, so their role in public policy debates has been scant; and women, facing the most serious sexual and reproductive health problems, are unfortunately the least likely to have a public voice in making decisions about design and implementation of programmers and services. The sexual and reproductive rights of adolescent girls in particular may be overlooked and they may be denied access to reproductive health services if they are unmarried.

Priority Areas of Intervention Necessary to Unblock these Constraints Women's groups and movements across the globe continue to promote as fundamental the need to respect and defend women's sexual and reproductive health rights. Women's groups and movements also continue to be fundamental to promoting these rights, but many find themselves under threat for this focus. Sexual and reproductive rights are critical for social and economic development. Without these rights, women and adolescent girls cannot make decisions about fertility. Data from the NFHS-3 survey on women's decision-making power shows that only about one third of the women interviewed took decisions on their own regarding household issues and their health. Data on women's mobility in India indicates the lack of choices women have, and that urban and educated women have more mobility choices than rural women. 70% of urban women from the highest education brackets and only about 40 percent of rural women without education were allowed to go to the market alone. Female literacy rates, School enrolment rates, and rates of households with safe drinking water and sanitation are all distinctly lower.

Mobility restrictions for women are dependent upon how the family and community view women's rights. Still a large part of women do not have sufficient autonomy regarding the value choices for their own life.

In India girls are valued only as wives and mothers, and/or marriage transfers any potential future gains from this investment to another family. As 1 in 7 girls marries before the age of 18 in the developing world (UNFPA 2012), early and forced marriage remains a key issue and an important factor limiting young women's engagement in both education and economic activities. Women's continued inability to control their own fertility means that childbirth limits their ability to engage in productive activities.

Even when reproductive health services are provided, this is not enough to ensure women's ability to access them. Men may see the decision over if and when to have children to be their decision, and large numbers of children may be read as a sign of male fertility and power, which becomes more important when masculinity is threatened. In many cultures, discussion of sexualities remains taboo.

The barriers begin with comparatively low investment in female education and health, they continue with restricted access to services and assets, and reflected on women's opportunities. So, the universal progress in development over the last three decades has not translated into proportional gains for women.

It emphasizes that women's mindset of 'dependency' must be changed so that they become conscious of their abilities to change themselves, their families, and their community. Their empowerment would lie in

becoming creative, self-dependent, individuals so as to find ways of learning new skills and approaches to become effective partners in development

Investment in the human capital, health and education, of women and girls is presented as a key way forward as witnessed by the MDGs. At global it shows clearly that supporting a stronger role for women contributes to economic growth, it improves child survival and overall family health, and it reduces poverty, thus helping to slow population growth rates. Research establishes a link between education and women's ability to control their fertility. Studies also show that paid work can promote greater understanding of sexual and reproductive rights among women. The logic is that 'educated, healthy women are more able to engage in productive activities, find formal sector employment, earn higher incomes and enjoy greater returns to schooling than are uneducated women, access and rights to those who do not conform to the heterosexual 'norm'.

In a country where pizza reaches home before an ambulance, resources remain a constant problem whether financial or human

Irrationally, cell phone reaches the tribal in hills, but not healthcare. At forest of Western Ghats, mobile phones ring loud in the serene atmosphere but lack of access to healthcare facilities are taking a toll on the health of the inhabitants there.

According to Bill Gates, founder of Bill and Melinda Gates Foundation, India needs to generate new health system models to achieve SDGs as India is no existing health system model to achieve the target, the SDGs are backed by a bold vision of the future that vision costs money that not yet available.

In India public spending on health amounts to just 1.1% of GDP compared to 2.9% and 4.1% in China and Brazil. Many countries are spending even more.2

There is only one doctor per 1,700 citizens in India; the World Health Organisation (WHO) stipulates a minimum ratio of 1:1,000. While the Union Health Ministry figures claim that there are about 6-6.5 lakh doctors available, India would need about four lakh more by 2020—50,000 for PHCs; 0.8 lakh for community health centres (CHC); 1.1 lakh for 5,642 sub-centres and another 0.5 lakh for medical college hospitals.

b) Method: Under the quantitative method, the primary data had collected from 100 adolescent married women. The data collected from 7 various districts of Maharashtra. For the survey tool has designed and approved from research guide. After data collection it has analyzed in epiinfo computer package

c) Future scope for further research.

As per UN report published by MDG report in 2011 reiterated the point that: "Reaching adolescents is critical to improving maternal health & achieving other Millennium Development Goals"

So findings of this research have useful insights for health policy development and public and NGO sector programming. Additionally, Reproductive Health in India highlights gaps in evidence and priority issues that still need to undertake further research. Pragramme planning especially to meet the gap of knowledge and practice.

It has been estimated that reproductive health problems are steeply rising – teenage marriage, sexually transmitted diseases (2/3rd of STD problem is estimated to be affecting the youth). AIDS is reported to be a critical problem among the youth in major metropolitan cities and drug addicts, high rates of anemia in female adolescents after menarche.

d) Findings:

- Out of the total respondent 40% had wedded before to complete their permitted marriage. Thus, it cleared that the regulatory body and social workers are powerless to stop the occurrence of customary practice.
- All had reported that immediately after their marriage, the marriage consummation had held. It shows that there is not any barrier of the marriage age for the act of consummation.
- Similarly, knowledge and practice it is observed that they do not able to differentiate protective and preventive measures should take /can utilize in the various stages of RH related issues.

- Overall, adolescent married women, their husband and their mother in laws believed that childbearing is normal phenomena with negligible associated risk and women suffered various gynecological problems where tradition of silence is the main reason for making the gap of knowledge and practice.

- Further, it reveals that they as widely accepted early child bearing as common incidence as well as health problems occurs during the time of pregnancy, so they prepares their mindset for facing such issues considering as common.
- However, no one is aware of abnormal presentation of fetus and various risks during pregnancy, during delivery.
- Women's specific illnesses, STI and RTI(STD) in details, however There it concludes that the majority of the respondent women are aware about when to registrar a pregnant women at health service center for the ANC checkup.
- Because early childbearing is commonly accepted behavior by a people in rural area and so they keep themselves the related information.
- Amazingly the PNC checkup they only believe is for newborn baby and his /her immunization and rests checkup, they enthusiastically go for it but they never think the checkup is also necessary for them after delivery. It find that they thought whatever the related issues raised in the period to a woman that automatically stops after PNC period.
- It is true that though not the women's empowerment and autonomy have a link with women's access to resources or material well-being, it is to be accepted that there is a variety of potential connections and there exists various forms of linkages among these variables.

- It is concluded that there is a necessity to look beyond economic resources or material prosperity and into cultural and social influences, which are playing a significant role in shaping the women's autonomy and agency.

e) Suggestions:

There is a need to understand that the concepts of empowerment and autonomy are sufficiently different.

f) Conclusion: Investing in women is central to sustainable development. And yet, despite these known returns, Indian women still face many barriers in contributing and benefiting from development especially from their health and socio-eco status.

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