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Anju

Research Scholar, Deptt of
EECM, COHS, CCSHAU, Hisar,
Haryana, India

Rajesh Dahiya

Assistant Professor, Deptt of
EECM, COHS, CCSHAU, Hisar,
Haryana, India

Sex ratio and health status across land holding category

Anju and Rajesh Dahiya

Abstract

Gender and sex are perceived as one by some individuals; rather these two terms have different meanings attached to it. Sex is a biology related term, whereas gender explains the society based roles for a male and female. Sex is by birth, and gender is acquired through socialization. Sex ratio is a composite indicator of women status in a society. The gender inequality faced by women was so much that many women claimed may God give sons to all. This is a fact and India has witnessed gender inequality from its early history due to its socio-economic and religious practices that resulted in a wide gap between the position of men and women in the society. Rural women face many health related problems like as-diabetes, blood pressure, anemia and drudgery related problems. Present study was conducted in Hisar district of Haryana state in randomly selected two blocks. Total 180 rural households (i.e. 60 from each small, medium and large land holding category) were taken as sample for present study. Highest sex ratio of family members across land holding category in small land holding (870/1000) found in above 65 years of age group in medium land holding (900/1000) in 0-6 years of age group. Surprisingly results pertaining to large land holding category sex ratio tilts in 0-6 years (1100/1000). While lowest sex ratio (666/1000) were found in 7-14 and above 65years age group. In small and medium land holding category more drudgery related problems in both male and female members but in the large land holding category blood pressure (41.6%) in male members and female face more anemia and diabetes related problems (30.0%).

Keywords: Sex ratio, health, category, gender, problems

Introduction

Sex is a biology related term, whereas gender explains the society based roles for a male and female. Sex is by birth, and gender is acquired through socialization. This socialization is done by parents, friends, and teachers. Media has an important role to play in identifying the gender roles. It is due to such gender based discriminations that hostility, abuse, and violence against women are commonly observed in society.

Sex ratio is a composite indicator of women status in a society. The 2011 census data presented a very gloomy scene for declining sex ratio. Alarmingly, the ratio of girls to boys in the 0 -6 age group has dwindled from 902 in the year 1981 to 830 in 2011 lowest in Haryana. For the country as a whole, the 0 – 6 sex ratio has declined from 962 in 1981 to 945 in 1991 to 927 in 2001, and further to 914 in 2011. While the 60 plus and overall sex ratio have risen, the 0 – 6 sex ratio has continued to decline.

The gender inequality faced by women was so much that many women claimed may God give sons to all. This is a fact and India has witnessed gender inequality from its early history due to its socio-economic and religious practices that resulted in a wide gap between the position of men and women in the society. Gender inequality in India refers to health, education, economic, inheritance, political, decision making, harassment and violence.

The prosperity in a rural area may be health if they are educated according to Aristotle, A sound body has a sound mind”. Hence good health ensure good thinking and good ensure thinking ensure a good Society and the good society comprises both men and women. About half of the rural population is women folk are illiterate and quite unaware about personal and public hygiene. Women takes low quantity of food so they face many health related problems and comes easily contact with diseases like as- anemia, blood pressure or other drudgery related problems. Rural women do more work as compared to man. Women do work in the home as well as agriculture work.

Objectives of the study

1. Sex ratio of family members across land holding category.
2. Association of sex ratio across land holding category

Corresponding Author:

Anju

Research Scholar, Deptt of
EECM, COHS, CCSHAU, Hisar,
Haryana, India

3. Health status of the family members across land holding category
4. Relationship between socio - economic variables and health status.

Review of literature

Kumar and Khan (2010) ^[6] concluded that higher female mortality rates were considered likely to be signal for discrimination against girls. One of the most extreme manifestations of son preferences is sex selective abortion.

Kumar (2012) ^[7] cited that development of children especially the girl child is the first priority on the country's development agenda, not because they are our supreme assets and also future human resources of the country. In view of the special needs and requirements of girl children, multi-pronged strategies, approaches and socio- cultural environment is imperative. The girls need to be provided proper care, protection, education, life skill education, health and nutrition, counselling, etc. The declining gender ratio in India is cause of concern. The child sex ratio in the recent decades has declined due to increasing female infanticides and giving lower priority to girl children.

Manhas and Dogra (2012) reported that existence of son preference is at an alarming high rate in Indian society.

Rai *et al.* (2018) informed that sex-selection practices need urgent intervention in view of the social harm, unwarranted gender bias, and diversion of resources from genuine medical need.

Saluja (2018) ^[14] revealed that there is sex-imbalance as there are more female adults than male adults in India. The focus should be on abolition of barbaric cultures, all forms of discrimination and self-empowerment of females.

Chanchani (2019) ^[2] reported that counter-intuitively, gender relations are relatively egalitarian when judged by indicators such as sex ratio, and attitudes towards female sexuality or remarriage, while son-preference in the family composition finds a sharp expression.

Times of india (2019) documented that Sirmaur block of Himachal Pradesh recorded a rise in the number of birth of girl child last year in the 0-1 age group, child sex ratio recorded at 1,004 girls for every 1,000 boys. In Sangrah block 634 girls were born against 602 boys, in Rajgarh block 315 girls against 372 boys, in Shillai block 530 girls against 563 boys, in Pacchad block 359 girls against 376 boys and in Nahan block 656 girls were born against 652 boys. This was due to implementation of strict laws and "Beti Bachao Beti Padao" programme was implemented in an effective manner.

Ramachandran (2011) ^[13] observed that differential access to nutrition within household was common in India. Preferential treatment in intra-household food distribution in favour of males is a deeply entrenched tradition. Women and girls customarily eat last, and when supplies are insufficient, eat least.

Sengupta (2011) ^[15] cited that women's health is of great importance both for their own sake and for the sake of future generations, but paradoxically remains the weakest and the most discriminated against in most countries. Maternal care in India has definitely improved in India since 1992 – 93, but with only 76 per cent women accessing any ante natal care and only 40.85 of births happening in a health facility. There is also a clear rural –urban gap in maternal care in India. Gender discrimination is strong in accessing health services as well.

Bhargava (2012) ^[1] found that rural women in India get less

opportunity to attend higher level of schools and therefore lack in knowledge and information about health and its perspectives. Around the world, reproductive health is one of the issues in improvement of overall health. Therefore a timely awareness on ongoing programs is required to reduce the health problems of rural women of the country.

Jakhar and Rajeshwari (2012) ^[5] reported that health of women is a matter of concern as due to child bearing and rearing processes women's health in terms of nutrition as well as medical care needs particular attention. Haryana is economically well-developed states yet the recent national family health survey recorded that one third of the total women are having poor nutritional status in terms of BMI. In Haryana only half of the total expecting women received full antenatal care and only 26 per cent women had institutional deliveries.

Mishra (2012) ^[11] found that issues and problems in the occupational health of women remain a challenge. Much of women's work was unreported and unrecognised, uncounted, and unpaid work in the home, agriculture, food production and marketing. Within the paid labour force, women are disproportionately concentrated in the informal sector, beyond the scope of industrial regulations, trade unions, insurance, or even data collection.

Naruka (2012) ^[12] observed that health status of women is affected by utilization of health care services which are provided to them. In Uttar Pradesh, only 20.7 per cent pregnant women visit health facilities for antenatal care, 9 per cent receive Iron and Folic Acid tablets, 21.8 per cent delivers their child at health facility and only 15 per cent mothers received postnatal health check-ups.

Vaidyanathan (2012) ^[18] reported declines in mortality over the years; these improvements have not been shared equally by all sections of society. While gender differentials have narrowed, females are exposed to high maternal mortality. Health programmes need to be focused up particular to target groups like women and children, infants in the neonatal and prenatal stages & elderly men and women. Drastic reductions in mortality can be achieved by providing better antenatal and postnatal services in rural areas, immunization of children and pregnant women and by ensuring spacing of births and laminating high – risk pregnancies.

Kushwah (2013) ^[8] expressed that health care access is important for women as women's body changes throughout her life time, from fetal development to post menopause. Many women also face huge social, economic and cultural barriers to having lifelong good health.

Mahanta and Nayak (2013) ^[9] observed that infant mortality rate was lower for north-eastern states. Female infant mortality rate was higher than male infant mortality rate in the region except in the states of Sikkim and Tripura. Life expectancy at birth was more for women than for men in North East and India. So it seems that the women of the region enjoyed better health status as compared to national level.

Dahiya and Yadav (2017) ^[3] highlighted the health hazards in agricultural operations perceived by women related to physical health hazards like skin allergies (66.6%), blisters (65.0%) and ergonomis like body pain (58.3%) and work pressure(68.5%) by women.

Suman (2019) ^[16] reported that education of women is a powerful tool for improving health and nutritional levels. Right to education, health and empowerment are the fundamental rights of every Indian women. The horrible

illegal practice of female foeticide has to be stopped by change in mind set of people through long term strategies.

Methodology

The present study was carried out in Hisar district of Haryana state. Out of the list of all blocks, two blocks namely Hisar-1 and Hisar-2 selected randomly. Two villages from each selected block viz., Gangwaand Dabra from Hisar-1 block and Kharia and Rawalwas kalan from Hisar -2 block were selected randomly. As the study was planned in rural area, list of land holding i.e. small land holding (1-2 hectare), medium land holding (greater than 2 hectare and less/ than equal to 5 hectare) & large land holding (greater than 5 hectare) was procured from all four villages. Total 180 rural households

were selected from all four villages covering 45 from each representing various land holding categories. (i.e. 15 each from small, medium and large).

Statistical analysis

The collected data were classified and tabulated depending on the kind of information required keeping in view the specific objectives of the study, the data were analyzed by using following statistical tools:

- Frequency and percentage
- Pearson’s Correlation coefficient

Results and Discussion

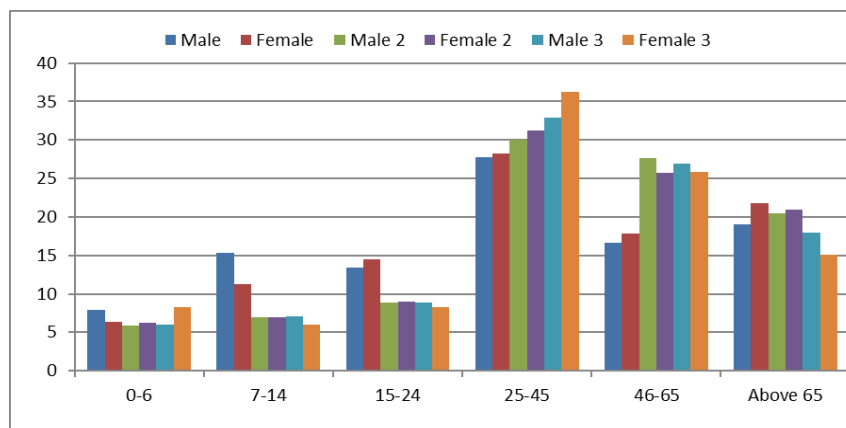
Table 1: Sex ratio of family members across land holding category

Age group	Land holding category								
	Small			Medium			Large		
	Male (n=163) F (%)	Female (n=124) F (%)	Sex Ratio	Male (n=170) F (%)	Female (n=144) F (%)	Sex Ratio	Male (n=167) F (%)	Female (n=132) F (%)	Sex Ratio
0-6	13(7.9)	8(6.4)	615	10(5.9)	9(6.2)	900	10(5.98)	11(8.3)	1100
7-14	25(15.3)	14(11.3)	560	12(7.0)	10(6.9)	833	12(7.1)	8(6.0)	666
15-24	22(13.4)	18(14.5)	818	15(8.9)	13(9)	866	15(8.9)	11(8.3)	733
25-45	45(27.7)	35(28.2)	777	51(30)	45(31.2)	882	55(32.9)	48(36.3)	872
46-65	27(16.6)	22(17.8)	814	47(27.6)	37(25.7)	787	45(26.9)	34(25.8)	755
Above 65	31(19.0)	27(21.8)	870	35(20.5)	30(20.9)	857	30(17.9)	20(15.1)	666
Over all sex ratio	760			842			790		

Data in Table 1 indicated that overall sex ratio of all family members were 760/1000, 842/1000 and 666/1000 across small, medium and large land holding categories respectively. Further the results regarding sex ratio of family members across small land holding category revealed that highest sex ratio (870/1000) was found in above 65years followed by 15-24 years age group (818/1000), 46-65 years (814/1000), 25-45years age group (777/1000), 0-6years age group (615/1000) and 7-14 years age group (560/1000). Further, results regarding medium land holding category it was observed that maximum sex ratio (900/1000) were in the 0-6years age group followed by 25-45years age group (882/1000), 15-24years age group (866/1000), above 65years age group (857/1000), 7-14years age group (833/1000) and 46-65 years age group (787/1000). Surprisingly results pertaining to large land holding category sex ratio tilts in 0-6 years (1100/1000). While lowest sex ratio (666/1000) were found in 7-14 and above 65years age group. It may be concluded that Haryana’s sex ratio at birth has increased to 923 in 2019, while it was

914 in 2018. The tilting trend might be due to programs like “Beti Bachao Beti Padhao” and PNMT act has been implemented in an effective manner. Moreover, to improve the sex ratio Punjab government is offering free treatment to girls upto 5 years of age in all public health facilities and awareness on girl child’s importance is spread through folk music and street plays.

The findings of the present study are in line with the results of Manhas and Dogra (2012) who reported that existence of son preference at an alarming high rate in Indian society. Kumar (2012) [7] supported this study where development of children especially the girl child is the first priority on the country’s development agenda, not because they are our supreme assets. The girls need to be provided proper care, protection, education, life skill education, health and nutrition, counselling, etc. besides creating opportunities for participation in development process. Kumar and Khan (2010) [6] also concluded that higher female mortality rates are considered likely to be signal for discrimination against girls.



Small Land Holding=M/F Medium Land Holding = M2/F2 Large Land Holding = M3/F3

Fig 1: Sex ratio of family members across land holding category

Table 2: Association of sex ratio across land holding category

Sex	Small F (%)	Medium F (%)	Large F (%)	Total F (%)	χ^2
Male	163(32.6)	170(34.0)	167(33.4)	500(55.5)	0.4439NS
Female	124(31.0)	144(36.0)	132(33.0)	400(44.5)	
Total	287(31.89)	314(34.89)	299(33.22)	900(100.0)	

The data presented in Table 2 show the association between sex ratio and land holding category. Which indicated that

there was no association between sex ratio and land holding category.

Table 3: Health status of the family members across land holding category

Health Parameters	Land Holding Category					
	Small		Medium		Large	
	Male (n=18) F (%)	Female (n=25) F (%)	Male (n=18) F (%)	Female (n=31) F (%)	Male (n=17) F (%)	Female (n=26) F (%)
Vaccination	10(55.5)	9(36.0)	10(55.5)	14(45.1)	10(58.9)	11(42.3)
Timely check-up	-	-	-	-	-	-
Immediate medication	8(44.4)	16(64.0)	8(44.4)	17(54.9)	7(41.1)	15(57.6)
General health						
problems	(n=14)	(n=30)	(n=13)	(n=19)	(n=12)	(n=20)
Diabetes	2(14.2)	5(16.6)	3(23.0)	2(10.5)	2(16.7)	6(30.0)
Heart Disease	3(21.4)	-	2(15.3)	1(5.2)	3(25.0)	-
Blood Pressure	1(7.1)	6(20.0)	3(23.0)	4(21)	5(41.6)	5(25.0)
Anemia	2(14.2)	9(30.0)	1(7.6)	5(26.3)	1(8.3)	6(30.0)
Drudgery related problems	6(42.9)	10(33.3)	4(30.7)	7(36.9)	1(8.3)	3(15.0)

Table 3 indicated that health status of family members across land holding category presented in Table 8 revealed that in small land holding category more than half of the male family members (55.5%) were taken vaccination followed by immediate medication (44.4%) while 64.0 per cent female members were taken immediate medication followed by vaccination (36.0%). Similar trend regarding vaccination and immediate medication results have seen in both medium and large land holding category. Further results regarding general health problems in Table 8 indicated that in small land holding category a sizeable number of male family members (42.9%) had drudgery related problems followed by heart disease (21.4%), diabetes (14.2%), anaemia (14.2%), and blood pressure (7.1%) whereas one third 33.3 per cent of the female members had drudgery related problems followed by anaemia (30.0%), blood pressure (20.0%) and diabetes (16.6%). Whereas in medium land holding category 30.7 per cent male members had drudgery related problems followed by diabetes (23.0%), blood pressure (23.0%), heart disease (15.3%) and anaemia (7.6%). However more than one third 36.9 per cent of the female members had drudgery related problems followed by anaemia (26.3%), blood pressure (21.0%), diabetes (10.5%) and heart disease (5.2%). It was amazing to note that from large land holding category 41.6 per cent male members had blood pressure problems followed by heart disease (25.0%), diabetes (16.7%) and anaemia (8.3%) whereas about one third (30.0%) of the female members had diabetes and anaemia, respectively followed by blood pressure (25.0%) and drudgery related problems (15.0%). Present findings also got support from Ramachandran (2011) [13] who concluded that differential access to nutrition within household is common in India. Preferential treatment in intra-household food distribution in favour of males is a deeply entrenched tradition. Bhargava (2012) [1] has cited that rural women in India lack in knowledge and information about health and its perspectives. And also got support from the findings of Dahiya and Yadav (2017) [3] reported the health hazards in agricultural operations perceived by women were physical health hazards

like skin allergies (66.6%), blisters (65.0%) and ergonomic like body pain (58.3%) and work pressure (68.5%) respectively.

Table 4: Relationship between socio - economic variables and health status

Independent variable	Health Status	
	Male	Female
Age	0.0198**	0.159*
Caste	-0.291**	-0.215**
Occupation of head of household	0.143	0.172*
Education of head of household	0.031	0.072
Income of head of household	0.315**	0.366**
Family occupation(sub activity)	0.025	0.024
Type of family	0.124	0.125
Size of family	0.146	0.079
Total family income	0.558**	0.541**
Social participation	0.124	0.070

The data presented in Table 4 show the association between the socio-economic variables with health of male members with age ($r=-0.019$), caste ($r=0.291$), family income ($r=-0.315$) and total family income ($r=-0.558$). Female health also established significant association at 5.0% level of significance with socio-economic variables like age ($r=0.159$), caste ($r=-0.215$), occupation ($r=0.172$), education ($r=0.072$), family income ($r=0.366$) and total family income ($r=0.541$).

Conclusion

In the 0-6 years of age group was lowest sex ratio (615/1000) in the small land holding category Surprisingly results pertaining to large land holding category sex ratio tilts in 0-6 years (1100/1000). The overall lowest sex ratio (760/1000) in small land holding category but however highest sex ratio (842/1000) in medium land holding category. Immediate medication more taken by females in small land holding category because they have more burden of work as compared to males. And drudgery related problems also face by small and medium land holding category both males and females.

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