International Journal of Arts and Social Science www.ijassjournal.com
ISSN: 2581-7922,
Volume 3 Issue 4, July-August 2020

Quality of life of Women in India

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Abstract: India opted for liberalization during 90's in anticipation that it would contribute a lot to the country's development scenario. Since its inception, India's GDP growth has been showing a spectacular rate.It is therefore, expected that this GDP growth must have some impact on the life and livelihood of the people, especially on the non-privileged ones. It is argued that liberalization introduces mechanization in almost all the fields there by leading to closer of traditional industries. Consequently, a huge level of unemployment was created among the unskilled/semi-skilled men and this incidence forced women to join the job market to a large extent for family sustenance. However, women are mainly concentrated in the informal sector for unskilled jobs. These women are in fact facing ruthless hardship because of excessive physical labour outside home in addition to the household duties and the oppression therein. In this backdrop, based on NFHS 3 (2005-06) data, present studyis an endeavour towards gauging the nature and extent of the quality of life of Indian women, and locates the determinants of the said quality of life.

Key words: *Quality of life, liberalization, women, burden*.

I. Introduction

Target of each nation is to achieve development. Usually development of a nation is judged either by its GDP growth rate or by per capita GDP. It is argued that GDP can never be a good indicator of development unless there is more or less egalitarian distribution of income. This instigates scholars to identify a suitable measure, which encompasses all the indicators of development including all spheres of life. Quality of life (QOL) includes the social as well as the economic factors so it can be the indicator of well-being. Therefore, scholars recommended it as an alternative measure of development. Acknowledging the importance of quality of life, Sustainable development goals (SDG) prescribed by UN set target for improved QOL for the developing countries.Although "quality of life" is relatively a new term, it is actually a modified version of the age-old concept "public happiness". Philosophers in different periods argued that the ultimate goal of human being is to obtain 'happiness', the 'highest good'. Political economists also identify 'happiness' as an important factor because it is a measurable quantity and is therefore useful to assess the achievement of the government of a country (Campbell, 1981). Overtime, the phrase "happiness" is gradually replaced by the term "well-being" or "quality of life"and various scholars from different angles tried to provide a suitable definition. From economic perspective, Fox (1974) tried to define QOL in terms of 'total income'. He argued that total time of an individual is allocated to maximise his/her utility. From marketing point of view, Sirgy, Samli and Meadow (1982) defined QOL in terms of 'Long Term Life Satisfaction'. From ecology point of view, QOL is explained in terms of human environed unit, the environment and their interaction (Bubloz, Eicher, Evers and Sontang, 1980). From human development perspective, QOL is defined in terms of satisfaction of human developmental needs in a community or society. In this regard, Rice (1984, p 157) provides a comprehensive definition of "*Quality of life'as the 'degree to which the experience of an individual's life satisfies that individual's wants and needs, both physical and psychological".* Rice argued that measurement of quality of life should address both

the objective and subjective quality of life. He defines objective quality of life (OQL) as the degree to which specified standards of living are satisfied by the objectively verifiable conditions, activities, and activity consequences of an individual's life and subjective quality of life as a set of effective beliefs directed toward one's life.

Thus, QOL can be judged from subjective as well as objective point of view. This gives rise to the debate that which of the approach is more efficient. However, both the approaches are interrelated, so, overall human QOL is a function of both the "level of human needs met" (objective) and the "extent to which individuals or groups are satisfied with this level" (subjective). Now, satisfaction of 'level of human needs met' implies a shift from lower order needs to higher order needs (Sirgy, 1985). Where, *lower order needs* signify basic and biological maintenance needs and *higher order needs* means self-fulfillment, psychological enhancement needs. All these needs may be grouped as objective and subjective needs. Thus to get a complete picture of QOL of an individual, both "objective" and "subjective" assessments should be combined together at multiple spatial and temporal scales (Costanza et.al, 2007).

According to Sirgy (1985), developing countries remain busy with fulfilling the lower order needs; conversely, developed countries remain busy with enhancing higher order needs. As a developing country, India is also continuously striving for satisfying lower order needs. After the initiation of globalization and economic liberalization in India, more than two decades has been over and the economy has witnessed several ups and downs in the GDP growth rate. Such movement of GDP must have some impact on the process of development. It is to observe how far it contributes to the betterment of the people, especially to the non-privilege done. Actually, it is not an easy task to roll on the process of development for a huge populous country like India, which suffers from multiple problems like religious, ethnic and class-related problems. Again, liberalization leads to closure of many traditional industries resulting in huge level of unemployment among unskilled or semi-skilled labour. Moreover, many of the women specific jobs are replaced by mechanization, therefore, for sustenance, women largely concentrated in the informal sector with much lower wage and security (Jhabvala & Sinha, 2002). According to National Sample Survey of India, during 2004-05 and 2011-12 women employment is found to decrease by 21.8 million in rural areas and increase by 2.1 million in urban areas (Thomas, 2014).

In this background, quality of life of women in the male dominated orthodox Indian society is not expected to be much impressive. However, in course of economic liberalization, various measures have been taken by Government of India to uplift the quality of life of its people especially the women as a vulnerable group of the society. It is expected that all these policies and programmes may have some influence on women's quality of life. Following United Nations, quality of life is generally measured by taking into account the life expectancy, education and per capita GDP. However, it can be argued that due to its multidimensional nature, these three variables are not sufficient to measure QOL efficiently. To have an efficient measure, it is recommended to increase the number of indicators including material and abstract variables. Proxy variables are used to assess the quality of life because it is not only a multi-dimensional concept but also latent by nature.

There exist several efforts to measure quality of life of Indian people but no single effort has been made to assess the quality of life of Indian women. In this circumstance, based on the Third National Family Health Survey (NFHS 3), 2005-06,present study is an endeavor to perceive the level of quality of life (QOL) of Indian women and to identify the determinants of quality of life of Indian women. Since NFHS 3 do not provide any information about abstract variables, so present study concentrates only on the material variables provided by NFHS 3.

II. Literature review:

Quite a good number of studies exist in the field of QOL. These studies can be categorized into three groups. First category of studies includes the measure of QOL either through objective or subjective well-being.

Second category of studies examines the correlation between objective and subjective well-being and the third category of studies provides an integrative approach covering both objective and subjective measures.

Most important study in the first category is the Charlotte Neighborhood (2010) quality of life study. It evaluates the quality of life in 73 inner city neighborhoods using a wide ranging set of variables. Those variables are aggregated into social, physical, crime, and economic dimensions, which are combined to create a quality of life index or score for each neighborhood. Based upon the cumulative variable scores individual neighborhoods are labeled as "stable," "threatened," or "fragile," this helps to review neighborhood's level of quality of life. This study substitute the terms "stable," "threatened," and "fragile" by "stable," "transitioning," and "challenged". Transitioning signifies a transitional position between the highest-ranking quality of life neighborhood statistical areas (NSAs) and the lowest ranked NSAs. Enhancement of purchasing power acts as a weapon to reduce poverty but it is observed that there exist considerable number of life satisfaction factors without which poverty cannot be removed effectively (Mariano Rojas, 2009). He suggests that public policy programs should aim not only to increase income of the poor as well as to improve their quality of life in other areas also.

In the second category, several studies attempt to identify the relationship between objective and subjective indicators of quality of life. Based on the countries like Nigeria and Japan, or Egypt and West Germany, Cantril (1965) corroborates that difference in per capita income does not create any difference in average level of life satisfaction between their citizens. Schneider (1975) establishes that the correlation between the objective characteristics and the life satisfaction measures is effectively zero. A US national survey (between1957 and 1972) observed that with rapidly rising economic and social facilities, proportion of "very happy" population decline steadily. This decline is most visible among the most affluent section of the population. Henshaw (1973) argued that the "conditions of satisfaction and happiness depends on the ability to survive, on a reasonable state of health; and on a multiplicity of things that permit or cause the achievement of desires or aspirations". This finding establishes a weak relationship between objective conditions and subjective well-being. Glatzer and Mohr, (1987) provide some explanation for weak relationship between objective conditions and subjective well-being. They are(a)an individual generally judge about his/her own improvements rather than valuing the improved conditions for their group as a whole, (b) individuals suppress their feelings of dissatisfaction due to social pressure, (c) usually expectations of an individual is adjusted to reality, (d) expression of dissatisfaction is culturally learned and to a certain extent independent of actual experience, (e) those living under favourable conditions are more confident to express criticism and dissatisfaction, (f) different individual standards of comparison result in varying levels of satisfaction in comparable social situations.

In the third category, S.M. Naomi et al (2002) compare the quality of life of the patient suffering from social anxiety disorder and patients with panic disorder. Naomi observes that quality of life of the patients having social anxiety disorder is better than that of the patients having panic disorder, i.e who suffers from both mental and physical impairments.

All these studies dealt with the quality of life of people in general but QOL of men and women are not same in the orthodox Indian society. Therefore, QOL of women should be judged separately to get a real picture but not a single study has assessed QOL of women till date. All the existing studies mainly measure the effect of various diseases or health related problems on their QOL. However, as an indicator of development, it is important to know the QOL of women who are treated as the backward section of the society.

III. Data and Methodology:

Data:

Present study is based on the unit level data extracted from Third National Family Health Survey (NFHS-3) conducted by IIPS during 2005-06 covering all the states in India. Till date it is the only largest source of data relating to women. It covers total 124,385 women including both married and unmarried aged between 15-49

years. This survey provides information on various socio-economic and QOL related attributes with respect to each respondent, at personal as well as at household level. Except a few, all the variables are qualitative in nature and the variables used in the study are recoded as par requirement of the study (Appendix). As NFHS 3 does not provide any data on subjective variables, so this study concentrates only on the objective variables. This study attempts to include as much variables as possible to measure the QOL, apprehending that it will represent a real quality of life. However, in absence of any detailed study, this may help in throwing light on the nature and extent of QOL of Indian women.

IV. Methods

A multi-step procedure is followed to identify the nature of QOL and its determinants. Firstly, a Quality of Life Index (QOLI) is constructed for each of the respondents. For construction of QOLI, initially all the QOL related information are identified from the survey data and then they are classified into six broad categories namely (1) Nutrition (2) Health (3) housing condition and amenities (4) Characteristics of Respondents (5) Experience of violence and (6) Autonomy of the respondent. Based on these six categories an QOLI is developed, which is then classified as low, medium and high using the formula (maximum – minimum)/3. Further, a regression analysis is carried out to identify the determinants of QOL.

V. Construction of QOL Index:

At first, all of the available variables are grouped under six categories in the following way:

(1) **Nutrition** includes consumption of the food items like (a) milk/curd (b)pulses or beans (c) green leafy vegetables (d) fruits (e) eggs (f) fish (g) chicken or meat.

(2) **Health** in cludes respondent's (a) BMI (b) anemia level (c) antenatal care received (d) place of delivery (e) number of child born.

(3) **Housing condition and amenities** consists of (a) ownership of house (b) type of house (c) toilet facilities (d) sources of drinking water (e) cooking medium (f) cook under chimney (g) electricity.

(4) **Respondent's Background Characteristics** includes their (a) level of education(b) occupation and(c) age at first marriage.

(5) **Experience of violence**

(6) **Autonomy of the respondent** represents the level of autonomy in the household decision making.

(7) **Recreation** means respondent attend movie at least once in a month.

Specific scores are then assigned to different responses according to the intensity of the scale (Appendix). Quality of life index (QOLI) is constructed for each respondent by combining all the above-mentioned categories. Initially for each respondent a ratio is estimated dividing sum of the recoded responses by total number of queries in each of the categories, namely nutrition, health, housing condition and amenities, background characteristics of the respondents, experience and frequency of violence and autonomy of the respondent and recreation. Then they are summed up to get the total value of the composite index.

QOLI for Kth respondent $= QOLI_K = \sum_{j=1}^{7} \sum_{i=1}^{Nj} x_{ijk} / N_j$, $0 \le QOLI_k \le 7$

Where x_{ijk} =i[th] decision of j[th] category for k[th] respondent, and $\sum_{i-1}^{N_j} x_{ijk} \leq N_j$; where N_j is the number of decision-making variables in j[th] category, and varies by j.

In the next step, a multiple regression analysis is carried out to identify the determinants of QOL. In this regard, QOLI is regressed on various socio-economic factors like place of residence (rural or urban), religion, caste, media exposure of the respondent, education and occupation of the partner, respondent's marital status and years of marriage, husband's alcoholism, illness of the respondent, household structure (joint or nuclear) and Wealth Index. The model used for multiple regression is

$$\text{QOLI} = \beta_0 + \sum_{i=1}^{k} \beta_i x_i + \varepsilon$$

Where $X = x_1, x_2, ...x_k$ stands for a vector of casual factors and β is a vector of corresponding regression coefficients, *i* stands for the number of exogenous variables, and ε is the random unobserved disturbance term with mean zero and constant variance.

VI. Profile of India:

Geographically India belongs to South Asia and is the second most populous country in the world. Population of India is 1.2 billion (See Table A1) and growth rate of population is 1.76 between 2001 and 2011. Sex ratio is 940 females per 1000 males and share of female to total population is 48 (2011). India is a densely populated nation; here 382 persons live per square kilometer. About 27.5 percent people live below poverty line (2004-05) in India. Even in 2011, both the female labour force participation rate and female work participation rates are 29 percent and 26 percent (Census of India) only. Of total employed women, only 20.4 percent are engaged in the organized sector (2010). Unemployment rate is 9.8 percent (2011).About 65 percent women (Census of India, 2011) are found to be literate in India. Female dropout rate from schools in 2010-11 is 25.4percent at primary level (I-V), 41.2 percent at elementary level (I-VIII) and 47.7 percent at secondary level (I-X).

Faster rate of urbanization along with government policy to provide shelter to the poor, leads to availability of increasing number of pucca houses (See Table A2) in India. However, sanitary situation is not much impressive in India, only47 percent of total houses have toilet facility (Census of India, 2011). Almost 86 percent households get safe drinking water and 67 percent houses had electricity connection (census of India, 2011). Mean age of marriage in India is 21 years (census of India, 2011). Average Life expectancy at age one is 68 years for female in India. In India, crude birth rate is 21 per thousand (2014), total fertility rate is 2.3 (2014) and crude death rate is 6.7 per thousand (2014). For girls, infant mortality rate and child mortality rate per thousand populations are42(SRS, 2012) and52(SRS, 2012). Maternal mortality rate is 178 per hundred thousand live births (SRS, 2010-12). However, female representation in top-level job and higher studies are considerably unimpressive. Share of women employment in IAS, IPS and IFS are found to be only 13.1 percent, 5.6 percent and 13.8 percent in 2010 (See Table A3). Share of women in both Medical Science and Engineering and Technology is insignificant, but percentage of female in Medical Science (4 percent) is far less than that of in Engineering& Technology (12 percent) courses in 2011-12(See Table A3).It is argued that political autonomy is an important key for women well-being because they can intervene at pro-women policymaking stage if required. This type of autonomy can be judged through percentage of female participation in various elections. In India, participation rate of women in various elections portray a disappointing image. In parliamentary election, only 11 percent (See Table A3) women are elected in 2014. Following the trend, only 9 percent women areelected in 2014 State Assembly election. In Gram Panchayat and Zilla Parishad election about 44 percent and 43 percent women elected, the reason is that in these bodies 30 percent seats are reserved for women.

VII. Findings

Quality of life is the function of basic needs enjoyed by the population of a nation. Like other developing nations, India also faces various obstacles with respect to basic needs; therefore, Sustainable Development goals (SDG) are set to achieve those within a stipulated period (2030). A standard quality of life indicates achievement of minimum basic needs for livelihood like shelter, safe drinking water, proper sanitation system, smokeless cooking, proper cooking oven and availability of some modern gadgets to make life easy.

A QOLI is developed to identify the actual level of quality of life achieved so far by Indian women. This particular index is computed taking into account the components such as *respondent's nutrition, health, housing condition and amenities, respondent's background characteristics, experience of violence and empowerment of women and their recreation in life* respectively. Pearson correlation establishes that among these components, empowerment of women, experience of spousal violence and their health are highly associated with QOLI (See Table 2).By classifying the QOLI as low, medium and high it is found that most of the women (61 percent) in India have medium level quality of life, about 39 percent have low level of quality of life and only 0.2 percent of women claim to have high level of quality of life (See Table 1).

Thus to enhance the QOL of women it is extremely important to identify its determinants particularly the crucial influencing factors. In this regard, regression analysis is carried out to locate the determinants of QOL for Indian women. It is found that almost all the factors are found to be significant at .01 percent level. Data demonstrates that QOLI of urban women is better than that of rural one (See Table 3). Among Hindu and Muslim, QOL of Muslim women is better than that of Hindu and QOL of caste Hindu women (higher castes) are lower than that of SC, ST and other backward class women. Media acts as a significant contributor to raise their QOL Marital status plays significant role in this regard. Married women who are living with their husbands lead better QOL relative to divorcee and widow; in fact, QOL of divorced, separated and widow is worst among all category of marital status. QOL of unmarried women is slightly better than divorcee and widow women.QOL of women is not much affected by their marital duration but it varies according to their relationship to household head. Women, who are either head or by relation nearer to head, always enjoy better QOL compared to other women (sister, daughter, daughter-in-law etc.) in the household. Physical illness is one of the important factors that lower the QOL of women. It becomes better for the women residing in the nuclear families compared to that of living in the joint families. Though higher education and occupation of husband enhance QOL of women but it worsened with their husband's alcoholism. It also varies proportionately with their economic standard.

VIII. Analysis and Discussion

Availability and fair access to minimum basic needs of life are the preconditions to achieve a standard quality of life. Usually, people in the developing countries are deprived of minimum basic needs and India is not an exception to this. It also suffers from the problems like poverty, inequality, deprivation, lower quality of life etc. However, it has some unique features that are not present in other developing nations. On the one hand, it is geographically a large country and on the other, it is the second most populous country in the world with high density of population. Moreover, it suffers from communal, ethnic, social and racial exclusion problems. All the above characteristics contribute to lower the QOL of Indian people. Moreover, Indian society is ruled by patriarchy since Vedic age, as a result separate codes of conduct are created for both males and females. All those codes of conduct are dictated by Manu (a saint of Vedic Age) in his writing "*Manu Smriti"* which is more or less in vogue till date (in modified form). According to his dictum, women are subject to subordination; they will get lower status relative to men and are destined to serve men. Such type of perception instigates oppression on women. After initiation of liberalization Indian society has undergone through sea change but the outlook towards women remain more or less same as was in the period of Manu. In this backdrop, status of women is not expected to be upto the mark and is reflected in the sex ratio of India, where 940 women are found per thousand males. Government of India therefore, take a special drive to uplift the status as well as the QOL of women so that they can be a part of mainstream developmental process, which may automatically contribute to their status. Shelter is one of the important factors of a standard QOL and it is found that housing situation is comparatively better in India due to Government's Indira Awaas Yojana (IAY) and Rajiv Awas Yojana (RAY) scheme with the aim to

help poor to live with dignity. About 86 percent women live in pucca and semi pucca houses, most of them live in their own house and majority of these houses have proper ventilation (See Table A3). IAY is a centrally sponsored scheme which sponsors rural Below Poverty Line (BPL) families (who are either houseless or having inadequate housing facilities) to construct a safe and durable shelter. And RAY target for a "Slum Free India" with inclusive and equitable cities in which every citizen has access to basic civic infrastructure, social amenities and decent shelter.

Individual Health and hygiene is largely dependent on adequate availability of safe drinking water and proper sanitation, therefore these two are taken as most important contributors of good QOL. Data suggests that nearly cent percent (88 percent) coverage of drinking water is observed. Government achieves success in this particular field. The sanitation facility available in the household has a huge impact on the living conditions and it is closely related to the health and hygiene of the household members. Despite earnest efforts, Government of India has failed to earn the requisite level. Till 2005-06 about 40 percent women do not have any toilet facility and use other means for this purpose. Probable reason of not using toilet may be manifold like lack of awareness, to carry on the tradition of not using toilet, does not have access to it and/or no provision. Of total women only 52 percent use flush toilet and about 50 percent of them have to share toilet with others which is mainly found in the slums.
Most of the women in India do not cook under chimney, may be they are not aware of it. In urban areas only some women (11 percent) cook under chimney and in the rural areas this conception is completely unknown to them. Majority of women use coal, fire woods and other as cooking medium. Only 35 percent women use LPG gas as cooking medium, may be due to lack of awareness as well as non-availability of LPG gas. Besides, various documents are required to avail LPG which is impossible for them to provide. Hence, women try to avail the hassle free cheaper mode of cooking medium ignoring the hazards of those. Startling fact is that majority of women (94 percent) are not covered by any sort of health insurance, probably due to non-availability of this type of privilege, lack of awareness about the scheme and above all the hazards they have to face. Lack of proper literacy keeps women ignorant about themselves. Within patriarchy they always remain busy with the family chores, therefore they get little time to know or think about the privileges they have and should have.

In Indian culture women generally take their meal after serving all of the family members. This ritual many time become responsible for the prevalence of mal- nutrition among women. With emergence of nuclear families along with the modernization of the society, prevailing notions began to be modified which are mostly observed in urban areas but not remarkably in rural areas (which constitutes the largest part of Indian population). Commonly Indian women are seen to survive on green leafy vegetables and pulses; rarely do they consume animal protein like milk, egg, fish, chicken or meat on regular basis (Table A4). The most tragic fact is that 13 percent women have never tasted milk; another 31 to 34 percent women never consumed egg, fish, chicken and meat. As a result, Indian women are found to have either underweight or normal weight; overweight or obese women are atypical in India and mainly traced in the urban affluent families (Table A5).Again Women in their teen found to have either underweight or normal weight and this is applicable for the women of each and every economic standard. Probably, most of the Indian families believe that the girls are destined to go to her marital home where they have to face many odds and hardship so they must be trained at their parental home to cope with various problems. Moreover, they are often exploited or compelled to adjust to provide privileges to the male members of the family. They are advised that the training for all sorts of adjustment will make their future life happy in their marital home. Therefore, in the name of adjustment they are often provided with poor level of nutrition and have to work hard. All these contribute to their under to normal to underweight.

Balanced diet helps to combat with diseases but due to religious reason or poverty or other social reasons, protein intake is normally low among Indian women; as a consequence, about 50 percent of women suffer from mild to severe anemia (Table A6). Rather prevalence of diseases like diabetes, asthma, thyroid and TB are much lower among Indian women may be those are under reported. Recreation is essential for both productivity as well as better life of an individual; therefore, recreation is extremely important for women who are almost occupied

whole day with various types of duties. It is observed that an infinitesimal percent of women (7 percent) are lucky enough to have some recreation (Table A3). This indicates that a large volume of women is deprived of recreation/leisure, probably patriarchal Indian society become terrified of the fact that any sort of recreation may generate self-awareness among them which may instigate them to raise voice against oppression. Once they began to raise voice, male dominated society will face trouble to keep them under control and this conception initiate violence on Indian women at home and outside home to cut short of every privilege of their life. Spousal violence is a common phenomenon in Indian women's married life (Table A7). It creates both physical problems and mental trauma among victimized women which in turn lower their confidence as well as the QOL. To get rid of such type of stresses they sometimes take refuge to addiction. In orthodox Indian society women have less freedom to grow any sort of addiction (though this conception is changing among the smart urban ladies). Therefore, addicted women hardly disclose it, for example only 7 percent women declared to chew tobacco, about 3 percent use pan masala, 1.8 percent ghutka (some sort of chewable tobacco) and 1.5 percent smokes cigarettes or bidi (Table A8).

Above observations from NFHS data justify the achievement of medium level quality of life (61%) in spite of paucity of minimum basic needs. In such a bleak atmosphere achievement of medium level QOL may be due to the efforts at government level making available some of the basic needs. During liberalization, job opportunities increase for both male and female, as a result, female employment as well as their purchasing power has increased in India. Enhanced purchasing power of women is generally used to enhance family welfare. All these together contribute to have medium level QOL.

In search of determinants of QOL, it is found that urban women have better quality of life than that of rural one, probably due to the fact that non availability or scarcity of many facilities in rural areas. Religion is found to be one of the important determinants of quality of life. In India, women belonging to other religion enjoy relatively more freedom in their life compared to Hindu and Muslim women, so enjoy better QOL. With respect to some aspect, caste Hindu women are worse off than lower caste women because they have to face various restrictions whereas lower castes women enjoy more freedom due to their financial participation. Two most important determinants of QOL are media and women's marital status. Media mainly generates awareness among women which helps them to fetch better QOL. Within patriarchy marriage becomes mandatory for Indian women, therefore those who decided to remain unmarried, or opt for divorce or separation are considered as rebel to the social system. Widows in the family are simply treated as dependents but divorced or separated are not respected in the family or society. Due to this ground they are often deprived and oppressed in the family/society which in turn reduces their QOL. Women who have power or close to power lobby (like head or wife of the head of the family) enjoy better QOL as power fetch them better nutrition, health, mental strength, privileges etc. Again illness of women lowers their QOL because they are deprived to avail all the facilities that can enhance their QOL and are often subject to negligence and disrespect in the family. Women residing in the nuclear family have better QOL than those who live in the Joint families, because women in the nuclear families can avail more freedom, more leisure and other facilities, which often remain beyond their reach in the joint families. Husband's higher education and occupation may help women to avail better QOL. The reason is higher economic condition bring all modern facilities within reach and it is reflected in the findings of the study. However, husband's alcoholism has such a strong negative impact that outweighs all the above mentioned positive effects thereby lowering QOL of the women.

IX. Conclusion

Following UN, India set Millennium Development Goals (MDG). All these targets aim for development of its people by enhancing their quality of life. Two of the MDG goals are related to safe drinking water and proper sanitation because improved management of drinking water supply and better sanitation are keys for reducing child morbidity and mortality, health of the population, along with social and economic progress. Regarding fulfillment of these extremely important goals, India has made significant progress in developing drinking water

infrastructure. However, in case of sanitation, the targeted goal has not been achieved yet. Therefore, to ensure basic sanitation facility to the mass of the population nation should adopt more focused initiatives and dedicated follow up to sustain the same. Housing condition in India is up to the mark, government become successful in providing proper shelter to its population. In order to make environment (both outdoor and indoor)pollution free, Government campaign for using LPG must be increased in the villages. Alongside the process of receiving LPG should be made easy to the individuals. But in reality majority of the women use coal or fire wood as medium of cooking. Smoke generated from this medium creates indoor air pollution which directly becomes responsible for asthma related diseases of women (Poddar and Chakrabarti, 2015). Women rarely visit to doctor for these types of diseases, may be many of them do not take asthma type of diseases seriously. Sometimes they won't like to spend money or can't bear the expense of treatment because bulk of the women is not covered by any sort of health insurance. It is not possible to cover each and every member of such a populous nation to provide health insurance but government must become little bit serious to provide health insurance to the women who do not have the capacity to bear the expenses of treatment. As a preventive measure, government must take the responsibility for easy availability of LPG to every household at a reasonable rate. Nutrition of women in India revealed an extremely pitiable status. Remarkable fact is that most of the Indian women hardly consume milk and animal protein; they survive mostly on green leafy vegetables leading to prevalence of anemia among women. Effect of poor diet is reflected in women's body mass index (BMI). Commonly Indian women are found to have underweight to normal weight..

Very few women suffer from the problem of obesity and they mainly belong to the rich families. In general, Indian women are so much involved with the household responsibility that they rarely get opportunity of leisure and whoever can manage leisure time, a meager percent of them are able to enjoy that. According to the estimated quality of life index (QOLI) most of the women yet leads medium level quality of life and a meager percent enjoy high level of quality of life. Rest has to carryon low level of quality of life. The target should be to raise the quality of life from lower to medium and then to high level. Though government adopts various policies and programmes to enhance the quality of life of its people but those attempts are not much effective for women. Government should take strict and sincere steps to solve the sanitation and indoor environment pollution problems which directly affects women's quality of life. It may be argued that the policies failed atgovernment level due to its top down approach where the benefits of the target groups are decided by the government; instead bottom up approach is much effective because solution comes from within the target groups. Accordingly, awareness regarding various contributing factors of quality of life should be generated among women along with other members of the society, so that they can directly participate in the process.

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Table 1: Percentage of women by level of Quality of Life in India, 2005-06

Level of QOLI	Percentage	Total
Low	38.9	48353
Medium	60.9	75649
High	0.2	234
Total	100.00	124236

Source: NFHS extracted data

Table 2: Pearson Correlation among QOLI and Its Components

	EI	HAI	HI	NI	RCI	Vio	Recreation	QOLI
EI	1.000	.029**	.170**	-.037**	.141**	.405**	.000	.862**
HAI	.029**	1.000	.003	-.060**	.075**	-.013**	.016**	.078**
HI	.170**	.003	1.000	.012**	.104**	.176**	-.014**	.358**
NI	-.037**	-.060**	.012**	1.000	-.099**	-.019**	-.053**	.234**
RCI	.141**	.075**	.104**	-.099**	1.000	.061**	.067**	.246**
Vio	.405**	-.013**	.176**	-.019**	.061**	1.000	-.022**	-.463**
Recreation	.000	.016**	-.014**	-.053**	.067**	-.022**	1.000	.086**
QIOLI	.862**	.078**	.358**	.234**	.246**	-.463**	.086**	1.000

** Correlation is significant at the 0.01 level (2-tailed).Note: EI: Empowerment, HAI: Housing and amenities, HI: Health, NI: Nutrition, RCI: Background characteristics of the respondent, Vio: spousal violence.

Table 3: Determinants of QOL of Indian Women, 2005-06

Model (QOLI is the dependent variable)	Coefficients		
	B	Std. Error	t
Constant	10.163	.077	131.392*
Urban/Rural	-.277	.014	-20.499*
Religion	.006	.001	8.053*
Caste or tribe	-.067	.005	-13.781*
Media	.544	.016	34.320*
Marital Status	.917	.012	79.705*
Marital Duration	.013	.010	1.356
Relation to Household Head	.328	.014	23.320*
Illness	.154	.029	5.296*
Husband's Education	.138	.011	12.913*
Husband's Occupation	.095	.010	9.302*
Husband Alcoholic	-.549	.012	-45.979*
Household Structure	.129	.014	9.141*
WI	.112	.011	10.445*

Appendix

All the study variables are recoded from the given standard codes of NFHS as follows:

QOL related Variables	Codes
Nutrition of women	(1) Never, (2) occasionally, (3) weekly, (4) daily
Antenatal care received during Pregnancy	(1) No, (2) Yes
Place of delivery	(1) Home, (2) Government hospitals/health sector (3) Private hospital /health sector
Suffering from Anemia or not	(1) Severe, (2) Moderate, (3) Mild, (4) Not anemic
BM I	(1) Underweight, (2) Normal, (3) Overweight, (4) Obese
Number of child born	(1) No child, (2) 1-4 children, (3) 5+
Age at marriage	(1) 2-14, (2) 15-26, (3) 27-45
Level of education of the respondent	(1) Illiterate and low, (2) Middle, (3) Higher
Occupation of the respondent	(1) No job, (2)Low, (3) Medium, (4) High
Whether watch movies or not	(1) No, (2) Yes
Type of house	(1) Katchha, (2) Semi pucca, (3) Pucca

Ownership of house	(1) No, (2) Yes
Toilet facilities	(1No facility, (2) Pit toilet, (3) Flush toilet
Sources of safe drinking water	(1) Surface water, (2) Tubewell/Dug well, (3) Piped water
Cooking medium of cooking	(1)Straw/shrubs/grass/Agricultural crop/animal dung/ other, (2)kerosene/coal/charcoal/wood, (3) electricity/LPG/biogas
Cooking done under chimney	(1) No, (2) Yes
Experience violence	(1) No, (2) Yes
Frequency of being beaten within last 12 months	(1) Not in last twelve months, (2) often, (3) sometimes
Independence of taking decisions at household level	(1) No, (2) Yes
Type of autonomy in decision making	(1) Mobility, (2) daily household decisions, (3) financial
Causal factors	
Place of residence	(1) Urban, (2) Rural
Religion	(1)Hindu, (2)Muslim,(3)Others
Caste	(1)Scheduled caste, (2)Scheduled tribe, (3)OBC (4)General
Education of partner	(1) Illiterate & low , (2) Medium, (3) Higher
Media	(1)No exposure, (2) Have exposure
Occupation of partner	(1) Low, (2) Medium, (3) High
Respondent's Marital Status	(1) Divorcee and separated, (2)Widow, (3)Unmarried (4)Married
Years of marriage	(1) 0-5, (2) 6-12, (3) 13-37
Husband Alcoholic	(1) No, (2) Yes
Relationship to household Head	(1)Others, (2)Wife, (3)Head
Illness of respondent	(1) No, (2) Yes
Household Structure	(1) Non-Nuclear, (2) Nuclear
Wealth Index	(1)Poor, (2)Middle, (3)Rich

Table A1: Women Related Various Socio Economic features in India

Population in thousands (2011)	1210193
Sex Ratio (females per 1000 males, 2011)	940
Density of population, 2011 (persons/sq. km)	382
Female(2011) in % :Labour force participation rate Work participation rate	29 26
Literacy rate (2011): Female	65.46
Female dropout rate from school education (2010-2011) : Primary (I-V) Elementary (I-VIII) Secondary (I-X)	 25.40 41.20 47.70
Women in higher studies (2011-12) in % : 1. Engineering and Technology 2. Medical Science	 12.00 3.71
Women in administrative services (2010) in % : 1. IAS 2. IPS 3. IFS	13.1 5.6 13.8
Women in politics : 1. Parliament (2014) 2. State Assembly (2014) 3. Gram Panchayat (2014-15)	11.20 9.00 43.81

4. ZillaParishad (2014-15)	43.19
Mean Age of Marriage	21
Life Expectancy of female (2011-15): Female	69.6
Crude Birth Rate (per thousand), 2014	21
Total Fertility Rate, 2014	2.3
Crude Death Rate	6.7
Female Mortality rate (per thousand), 2012	
1. Infant Mortality	42
2. Child Mortality Rate	52
Maternal Mortality Ratio per 100,000 live births (2010-12)	178

Source: Census of India, 2011, NSSO 62nd Round, Education in India, Statistics of School Education 2010-11, Government of India Ministry of Human Resource Development Bureau of Planning, Monitoring & Statistics New Delhi 2014, Civil List, DoPT, Indian Police Service, Indian Forest Service, 2011-12, Election Commission of India, 2014, The State Panchayats, 2014-15. Sample Registration System, Office of the Registrar General, India, Ministry of Home Affairs,2011& 2013.

Table A2: Distribution of Women by Condition of Living in India, 2005-06

Types		Percentage
Type of Houses:	Kachha	13.7
	Semi Pucca	39.9
	Pucca	45.9
Ownership of house*		81.4
Houses with windows*	Yes	73.27
Sources of drinking water:	Piped water into dwelling	19.06
	Piped water	28.75
	Tubewell/Dug well	39.75
	Surface water	12.44
Toilet Facilities:	Flush Toilet	51.58
	Pit Toilet	7.95
	No Facility	35.79
	Other	4.68
Toilet Facilities Shared*	Yes	25.74
Types of cooking devises*	Stove	5.91
	Chullah	76.35
	Open Fire	10.72
	Other	0.09
Cooking done under chimney*	Yes	10.5
Cooking medium*	Electricity	0.71
	LPG/Natural gas	34.64
	Biogas	0.46
	Kerosene	3.71
	Coal, Lignite	1.67
	Charcoal	0.54
	Wood	41.79
	Straw/Shrubs/Grass	2.73
	Agricultural Crop	2.27
	Animal Dung	7.01

	Other	0.03
Health scheme/insurance*	Yes	6.3
Has- Telephone Refrigerator Motor cycle Car		20.4 24.3 22.4 5.1
Attended cinema hall/theatre once in a month		6.5

Source: NFHS extracted data. Note: * Rest of the population is not dejure Resident

Table A3: Distribution of Indian women by nutrition chart

Mother consumed	Never	Daily	Weekly	Occasionally
Milk or curd	13.1	39.0	15.8	32.1
Pulses or beans	1.0	50.0	37.1	11.9
Green leafy vegetables	0.3	64.0	28.0	7.7
Fruits	2.8	17.6	29.9	49.7
Eggs	31.2	4.5	29.7	34.7
Fish	33.9	8.5	23.9	33.6
Chicken or meat	31.6	1.8	24.7	41.9

Source: NFHS extracted data

Table A4: Distribution of women by wealth index (WI), Age and BMI in India, 2005-06

WI	Age	BMI				
		Underweight	Normal	Overweight	Obese	Total
	15-25	47.4	47.0	4.8	0.8	51025
	26-40	33.2	47.7	14.8	4.3	52801
	41-49	26.4	44.4	21.0	8.3	18707
	Total	38.0	47.0	12.0	3.0	122533
Poor	15-25	42.0	52.5	1.2	4.3	13217
	26-40	41.1	51.8	3.4	3.6	13773
	41-49	41.0	49.9	4.8	4.3	4216
	Total	41.5	51.9	2.7	4.0	31206
Middle	15-25	34.0	57.5	4.0	4.4	23153
	26-40	23.3	57.5	12.8	6.4	22356
	41-49	18.6	56.1	17.6	7.6	7539
	Total	27.3	57.3	9.7	5.7	53048
Rich	15-25	26.3	56.0	8.7	9.0	14656
	26-40	9.0	50.0	25.4	15.5	16672
	41-49	4.8	39.9	32.7	22.6	6951
	Total	14.9	50.5	20.4	14.3	38279

Source: NFHS extracted data, Note: BMI being 12.4-18.4= Underweight, 18.5-24.9= Normal, 25.0-29.9= overweight, 30.0+ = Obese

Table A5: Percentage of women suffering from various diseases in India, 2005-06

Type of disease	Percentage	Go for treatment	Percentage
Anemic: Severe	1.6	1.Govt/Public sector	40.1
Moderate	13.4	2. NGO/Trust hospital	0.4
Mild	37.0	3. Private hospital	55.6
Not anemic	48.0	4. Other	3.8
Total	112714	Total	118186
Diabetis	1.1		
Asthma	1.7		
Thyroid	1.1		
Suffer from TB	0.4		

Source: NFHS extracted data

Table A6: Distribution of Indian women abused at Home, 2005-06

How often physically hurt husband in last 12 months	% of Indian women facing domestic violence
1. Not in last 12 months	36.3
2. Often	6.9
3. Sometimes	55.6

Source: NFHS extracted data

Table A7: Distribution of women by various addictions in India, 2005-06

Types of addiction	Yes
Smokes cigarettes/Bidi	1.5
Smoke pipe or cigar	0.2
Uses snuff	0.6
Smokes paan masala	3.3
Smoke ghutka	1.8
Smoke other chewing tobacco	6.6
Smoke other	0.7

Source: NFHS extracted data

Variables Grouped under the Components of QOLI

Components of QOL	Variables
Nutrition	(a) milk/card (b) pulses or beans (c) green leafy vegetables (d)fruits (e) eggs (f) fish (g) chicken/meat
Health	(a) BMI (b) anemia level (c) antenatal care received (d) place of delivery (e) number of child born
Housing condition and amenities	(a) ownership of house (b) type of house (c) toilet facilities (d) sources of drinking water (e)cooking medium (f)cook under chimney (g) electricity
Respondent's Characteristics	(a) level of education (b) occupation (c) age at first marriage.
Experience of violence	whether respondent face spousal violence at home
Autonomy of the respondent	Level of autonomy in the household decision making
Recreation	Attend cinema