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Original Research Paper

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WOMEN'S HEALTH IN INDIA

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ABSTRACT

Women's health in India can be examined in terms of multiple indicators, which vary by geography, socioeconomic standing and culture. To adequately improve the health of women in India multiple dimensions of wellbeing must be analysed in relation to global health averages and also in comparison to men in India. Health is an important factor that contributes to human wellbeing and economic growth. Currently, women in India face a multitude of health problems, which ultimately affect the aggregate economy's output. Addressing the gender, class or ethnic disparities that exist in healthcare and improving the health outcomes can contribute to economic gain through the creation of quality human capital and increased levels of savings and investment.

KEYWORDS :

Introduction

Women's health differs from that of men in many unique ways. Women's health is an example of population health, where health is defined by the World Health Organization as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Often treated as simply women's reproductive health, many groups argue for a broader definition pertaining to the overall health of women, better expressed as "The health of women". These differences are further exacerbated in developing countries where women, whose health includes both their risks and experiences, are further disadvantaged.

Although women in industrialised countries have narrowed the gender gap in life expectancy and now live longer than men, in many areas of health they experience earlier and more severe disease with poorer outcomes. Gender remains an important social determinant of health, since women's health is influenced not just by their biology but also by conditions such as poverty, employment, and family responsibilities. Women have long been disadvantaged in many respects such as social and economic power which restricts their access to the necessities of life including health care, and the greater the level of disadvantage, such as in developing countries, the greater adverse impact on health.

Definitions and scope

Women's experience of health and disease differ from those of men, due to unique biological, social and behavioral conditions. Biological differences vary from phenotypes to the cellular biology, and manifest unique risks for the development of ill health. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Women's health is an example of population health, the health of a specific defined population.

Women's health has been described as "a patchwork quilt with gaps". Although many of the issues around women's health relate to their reproductive health, including maternal and child health, genital health and breast health, and endocrine (hormonal) health, including menstruation, birth control and menopause, a broader understanding of women's health to include all aspects of the health of women has been urged, replacing "Women's Health" with "The Health of Women". The WHO considers that an undue emphasis on reproductive health has been a major barrier to ensuring access to good quality health care for all women Conditions that affect both men and women, such as cardiovascular disease, osteoporosis, also manifest differently in women. Women's health issues also include medical situations in which women face problems not directly related to their biology, such as gender-differentiated access to medical treatment and other socioeconomic factors. Women's health is of particular concern due to widespread discrimination against women in the world, leaving them disadvantaged.

The United Nations ranks India as a middle-income country. Findings from the World Economic Forum indicate that India is one of the worst countries in the world in terms of gender inequality. The 2011 United Nations Development Programme's Human Development Report ranked India 132 out of 187 in terms of gender inequality. The value of this multidimensional indicator, Gender Inequality Index (GII) is determined by numerous factors including maternal mortality rate, adolescent fertility rate, educational achievement and labour force participation rate. Gender inequality in India is exemplified by women's lower likelihood of being literate, continuing their education and participating in the labour force.

Gender is one of the main social determinants of health—which include social, economic, and political factors—that play a major role in the health outcomes of women in India and access to healthcare in India. Therefore, the high level of gender inequality in India negatively impacts the health of women. Studies have indicated that boys are more likely to receive treatment from health care facilities compared to girls, when controlled for SES status.

The role that gender plays in health care access can be determined by examining resource allocation within the household and public sphere. Gender discrimination begins before birth; females are the most commonly aborted sex in India. If a female fetus is not aborted, the mother's pregnancy can be a stressful experience, due to her family's preference for a son. Once born, daughters are prone to being fed less than sons, especially when there are multiple girls already in the household. As women mature into adulthood, many of the barriers preventing them from achieving equitable levels of health stem from the low status of women and girls in Indian society, particularly in the rural and poverty-affected areas.

Amartya Sen has attributed access to fewer household resources to their weaker bargaining power within the household. Furthermore, it has been found that Indian women frequently underreport illnesses. The underreporting of illness may be contributed to these cultural norms and gender expectations within the household. Gender also dramatically influences the use of antenatal care and utilisation of immunisations.

A study by Choi in 2006 found that boys are more likely to receive immunisations than girls in rural areas. This finding

has led researchers to believe that the sex of a child leads to different levels of health care being administered in rural areas. There is also a gender component associated with mobility. Indian women are more likely to have difficulty traveling in public spaces than men, resulting in greater difficulty to access services.

At the turn of the 21st Century India's health care system is strained in terms of the number of healthcare professionals including doctors and nurses. The health care system is also highly concentrated in urban areas. This results in many individuals in rural areas seeking care from unqualified providers with varying results. It has also been found that many individuals who claim to be physicians actually lack formal training. Nearly 25 percent of physicians classified as allopathic (mainstream medical) providers actually had no medical training; this phenomenon varies geographically.

Women are negatively affected by the geographic bias within implementation of the current healthcare system in India. Of all health workers in the country, nearly two thirds are men. This especially affects rural areas where it has been found that out of all doctors, only 6 percent are women. This translates into approximately 0.5 female allopathic physicians per 10,000 individuals in rural areas.

A disparity in access to maternal care between rural and urban populations is one of the ramifications of a highly concentrated urban medical system. According to Government of India National Family Health Survey (NFHS II, 1998–1999) the maternal mortality in rural areas is approximately 132 percent the number of maternal mortality in urban areas.

The Indian government has taken steps to alleviate some of the current gender inequalities. In 1992, the government of India established the National Commission for Women. The commission was meant to address many of the inequalities women face, specifically rape, family and guardianship. However, the slow pace of change in the judicial system and the aforementioned cultural norms have prevented the full adoption of policies meant to promote equality between men and women.

In 2005 India enacted the National Rural Health Mission (NRHM). Some of its primary goals were to reduce infant mortality and also the maternal mortality ratio. Additionally, the NHRM aimed to create universal access to public health services and also balance the gender ratio. However, a 2011 research study conducted by Nair and Panda found that although India was able to improve some measures of maternal health since the enactment of the NHRM in 2005, the country was still far behind most emerging economies.

The high incidence of breast lumps among Adivasi women of Adilabad in Telangana has created apprehension of more serious health impacts for this remote population. "Leave alone breast cancer or any other type of carcinoma, even routine mammarian infections were unknown among indigenous people belonging to the Gond, Pardhan, Kolam and Thotti," points out Dr. Thodsam Chandu, the District Immunisation Officer, himself a Gond

Nutrition plays a major role in and individual's overall health; psychological and physical health status is often dramatically impacted by the presence of malnutrition. India currently has one of the highest rates of malnourished women among developing countries. A study in 2000 found that nearly 70 percent of non-pregnant women and 75 percent of pregnant women were anemic in terms of iron-deficiency. One of the main drivers of malnutrition is gender specific selection of the distribution of food resources.

A 2012 study by Tarozzi have found the nutritional intake of early adolescents to be approximately equal. However, the rate of malnutrition increases for women as they enter adulthood. Furthermore, Jose et al. found that malnutrition increased for ever-married women compared to non-married women.

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