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The Health Status of Women in Indian Society

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INTRODUCTION:

Though every society claims to have accorded high status to women, yet the reality is quite contrary. Women in general play a pivotal role in the society. They provide services without any remuneration and reward; yet they are regarded as a source of misery and a dependent category on the male members of their families. The traditional belief has always been that they are supposed to move and work within the periphery of their homes. Culturally construed traditional image of the wife is to bear and rear children. Thus, their status is considered to be subjugated and dependent. This article uses Scale of Change theory as a framework to guide global health researchers to synergistically target women's health outcomes in the context of improving their right to freedom, equity, and equality of opportunities. We hypothesize that health researchers can do so through six action strategies. These strategies include (1) becoming fully informed of women's human rights directives to integrate them into research, (2) mainstreaming gender in the research, (3) using the expertise of grass roots women's organizations in the setting, (4) showcasing women's equity and equality in the organizational infrastructure, (5) disseminating research findings to policymakers in the study locale to influence health priorities, and (6) publicizing the social conditions that are linked to women's diseases. Our intent is to offer a feasible approach to health researchers who, conceptually, may link women's health to social and cultural conditions but are looking for practical implementation strategies to examine a women's health issue through the lens of their human rights.

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

Malnutrition In India

Gender disparities in nutrition are evident from infancy to adulthood. In fact, gender has been the most statistically significant determinant of malnutrition among young children and malnutrition is a frequent direct or underlying cause of death among girls below age 5. Girls are breast-fed less frequently and for shorter durations in infancy; in childhood and adulthood, males are fed first and better. Adult women consume approximately 1,000 fewer calories per day than men according to one estimate from Punjab. Comparison of household dietary intake studies in different parts of the country shows that nutritional equity between males and females is lower in northern than in southern states.

Nutritional deprivation has two major consequences for women: they never reach their full growth potential and anemia. Both are risk factors in pregnancy, with anaemia ranging from 40-50 percent in urban areas to 50-70 percent in rural areas. This condition complicates childbearing and result in maternal and infant deaths, and low birth weight infants.

One study found anemia in over 95 percent of girls ages 6-14 in Calcutta, around 67 percent in the Hyderabad area, 73 percent in the New Delhi area, and about 18 percent in the Madras area. This study states, "The prevalence of anemia among women ages 15-24 and 25-44 years follows similar patterns and levels. Besides posing risks during pregnancy, anemia increases women's susceptibility to diseases such as tuberculosis and reduces the energy women have available for daily activities such as household chores, child care, and agricultural labor. Any severely anemic individual is taxed by most physical activities, including walking at an ordinary pace.

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 resource.

A 2012 study 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.

Maternal malnutrition has been associated with an increased risk of maternal mortality and also child birth defects. Addressing the problem of malnutrition would lead to beneficial outcomes for women and children.

Breast Cancer

India is facing a growing cancer epidemic, with a large increase in the number of women with breast cancer. By the year 2020 nearly 70 percent of the world's cancer cases will come from developing countries, with a fifth of those cases coming from India.

Much of the sudden increase in breast cancer cases is attributed to the rise in Westernisation of the country. This includes, but is not limited to, westernised diet, greater urban concentrations of women, and later child bearing. Additionally, problems with India's health care infrastructure prevent adequate screenings and access for women, ultimately leading to lower health outcomes compared to more developed countries. As of 2012, India has a shortage of trained oncologistsand cancer centres, further straining the health care system.

REPRODUCTIVE HEALTH

The lack of maternal health contributes to future economic disparities for mothers and their children. Poor maternal health often affects a child's health in adverse ways and also decreases a woman's ability to participate in economic activities. Therefore, national health programmes such as the National Rural Health Mission (NRHM) and the Family Welfare Programme have been created to address the maternal health care needs of women across India.

Although India has witnessed dramatic growth over the last two decades, maternal mortality remains stubbornly high in comparison to many developing nations. As a nation, India contributed nearly 20 percent of all maternal deaths worldwide between 1992 and 2006.The primary reasons for the high levels of maternal mortality are directly related to socioeconomic conditions and cultural constraints limiting access to care.

However, maternal mortality is not identical across all of India or even a particular state; urban areas often have lower overall maternal mortality due to the availability of adequate medical resources. For example, states with higher literacy and growth rates tend to have greater maternal health and also lower infant mortality.

HIV/AIDS

As of July 2005, women represent approximately 40 percent of the HIV/AIDS cases in India. The number of infections is rising in many locations in India; the rise can be attributed to cultural norms, lack of education, and lack of access to contraceptives such as condoms. The government public health system does not provide adequate measures such as free HIV testing, only further worsening the problem.

Cultural aspects also increase the prevalence of HIV infection. The insistence of a woman for a man to use a condom could imply promiscuity on her part, and thus may hamper the usage of protective barriers during sex. Furthermore, one of the primary methods of contraception among women has historically been sterilisation, which does not protect against the transmission of HIV.

The current mortality rate of HIV/AIDS is higher for women than it is for men. As with other forms of women's health in India the reason for the disparity is multidimensional. Due to higher rates of illiteracy and economic dependence on men, women are less likely to be taken to a hospital or receive medical care for health needs in comparison to men.This creates a greater risk for women to suffer from complications associated with HIV. There is also evidence to suggest that the presence of HIV/AIDS infection in a woman could result in lower or no marriage prospects, which creates greater stigma for women suffering from HIV/AIDS.

Reproductive Rights

India legalised abortion through legislation in the early 1970s. However, access remains limited to cities. Less than 20 percent of health care centres are able to provide the necessary services for an abortion. The current lack of access is attributed to a shortage of physicians and lack of equipment to perform the procedure.

The most common fetus that is aborted in India is a female one. Numerous factors contribute to the abortion of female fetuses. For example, women who are highly educated and had a firstborn female child are the most likely to abort a female. The act of sex-selective abortion has contributed to a skewed male to female ratio. As of the 2011 census, the sex ratio among children aged 0–6 continued a long trend towards more males.

The preference for sons over daughters in India is rooted in social, economic and religious reasons. Women are often believed to be of a lower value in society due to their non bread winner status. Financial support, old age security, property inheritance, dowry and beliefs surrounding religious duties all contribute to the preference of sons over daughters. One of the main reasons behind the preference of sons is the potential burden of having to find grooms for daughters. Families of women in India often have to pay a dowry and all expenses related to marriage in order to marry off a daughter, which increases the cost associated with having a daughter.

Cardiovascular Health

Cardiovascular disease is a major contributor to female mortality in India. Women have higher mortality rates relating to cardiovascular disease than men in India because of differential access to health care between the sexes. One reason for the differing rates of access stems from social and cultural norms that prevent women from accessing appropriate care. For example, it was found that among patients with congenital heart disease, women were less likely to be operated on than men because families felt that the scarring from surgery would make the women less marriageable.

Furthermore it was found that families failed to seek medical treatment for their daughters because of the stigma associated with negative medical histories. A study conducted by Pednekar et al. in 2011 found that out of 100 boys and girls with congenital heart disease, 70 boys would have an operation while only 22 girls will receive similar treatment.

The primary driver of this difference is due to cultural standards that give women little leverage in the selection of their partner. Elder family members must find suitable husbands for young females in the households. If women are known to have adverse previous medical histories, their ability to find a partner is significantly reduced. This difference leads to diverging health outcomes for men and women.

Mental Health

Mental health consists of a broad scope of measurements of mental well being including depression, stress and measurements of self-worth. Numerous factors affect the prevalence of mental health disorders among women in India, including older age, low educational attainment, fewer children in the home, lack of paid employment and excessive spousal alcohol use. There is also evidence to suggest that disadvantages associated with gender increase the risk for mental health disorders. Women who find it acceptable for men to use violence against female partners may view themselves as less valuable than men. In turn, this may lead women to seek out fewer avenues of healthcare inhibiting their ability to cope with various mental disorders.

One of the most common disorders that disproportionately affect women in low-income countries is depression. Indian women suffer from depression at higher rates than Indian men. Indian women who are faced with greater degrees of poverty and gender disadvantage show a higher rate of depression. The difficulties associated with interpersonal relationships— most often marital relationships—and economic disparities have been cited as the main social drivers of depression.

It was found that Indian women typically describe the somatic symptoms rather than the emotional and psychological stressors that trigger the symptoms of depression. This often makes it difficult to accurately assess depression among women in India in light of no admonition of depression. Gender plays a major role in postnatal depression among Indian women. Mothers are often blamed for the birth of a female child. Furthermore, women who already have a female child often face additional pressures to have male children that add to their overall stress level.

Women in India have a lower onset of schizophrenia than men. However, women and men differ in the associated stigmas they must face. While men tend to suffer from occupational functioning, while women suffer in their marital functioning. The time of onset also plays a role in the stigmatisation of schizophrenia. Women tend to be diagnosed with schizophrenia later in life, oftentimes following the birth of their children. The children are often removed from the care of the ill mother, which may cause further distress.

Depression

Depression affects more women than men. It is a physically debilitating and an emotionally painful condition. A depressed person finds it difficult to enjoy anything or even function normally. Reasons could be many – trauma, grief, love and relationship troubles, genetic,

alcohol consumption, obesity, etc. Women have an added risk factor– the hormones. Hormonal changes, particularly after pregnancy (postpartum) or around menopause, can trigger the condition. 80% of all mothers experience postpartum depression of one form or another. Though most of them usually get over normal 'baby blues' in a few days or at most a couple of weeks, some women take longer to recover and suffer more severe symptoms. They may exhibit suicidal tendencies, frequent bouts of crying, sleep disturbance, weight loss, a feeling of guilt and a general lack of interest in their surroundings. Some women suffer from a serious condition called postpartum psychosis which results in hallucination, delusion and obsessive thoughts particularly involving the baby. Recognizing depression and seeking help is the first and most critical towards recover

Autoimmune diseases

In general, women are more resilient than men and are more resistant to disease. Women produce a more vigorous immune response and increased antibody production, thanks to their sex hormones like oestrogen and progesterone. But this very advantage has a downside. Autoimmune diseases affect more women than men. Autoimmune diseases are a group of more than 80 disorders in which the immune system produces antibodies against the body's tissues and attacks and destroys the body's healthy tissue instead of protecting it from infection or disease. They involve almost every human organ system. Genetic, hormonal and environmental factors are suspected to be the risk factors. Although each disease is unique, many share same symptoms like fatigue, fever, dizziness, etc. Many symptoms resemble those of other health problems and make it difficult to get a diagnosis. Diagnosing an autoimmune disease may need a series of tests and procedures and can sometimes take years.

Osteoporosis

Women require certain essential nutrients like iron, folic acid and most importantly calcium during various stages in their life. The term osteoporosis is synonymous with women, low calcium, weak bones leading to fractures. Vitamin D deficiency caused by low exposure to sunlight and low dietary vitamin D are the main causes. Over-exercising (e.g. marathon running), especially in young women, increases osteoporosis risk because of excessive weight loss and early termination of menstruation. Osteoporosis is often asymptomatic until a bone fractures, then an X-ray and bone density measurement confirms the diagnosis. Prevention and treatment choices include lifestyle changes such as no smoking, minimizing alcohol intake, regular (weight-bearing) exercise, maintaining healthy weight, low-salt and calcium plus vitamin D-rich diet.

Arthritis

Women are affected with arthritis more than men. They usually develop osteoarthritis after the age of 40. Arthritis is not a single disease – there are over 100 different forms of arthritis. It is a collective term for different individual illnesses, with different features, treatments, complications, and prognoses. The similarity is that they have a tendency to affect the joints and many have the possibility to affect other internal parts of the body. It is mostly related to

wear and tear of cartilage (osteoarthritis) or associated with an overactive immune system causing inflammation (rheumatoid arthritis). Some of the causes of arthritis are hereditary factors, infections (bacterial and viral), lack of joint fluid, autoimmunity, etc. Arthritis causes pain and limits the function of your joints. If your arthritis is due to inflammation of the joints then you may experience joint swelling, redness, warmth and stiffness.

Obesity

Compared to people with a healthy weight, obese and overweight individuals have an increased risk of diabetes, heart disease and stroke, and tend to die younger. Obesity in women also causes menstrual abnormality, infertility and miscarriage. Obese pregnant women are at an increased risk of infections, pregnancy hypertension and gestational diabetes. Obese and overweight people are gaining weight rapidly in India. According to data from the Obesity Foundation India, more than 3 percent of Indians are clinically obese and a whopping 25 percent are overweight.

Metabolic syndrome

Metabolic syndrome, (syndrome X) is a set of abnormalities related to the body's metabolism in which insulin-resistant diabetes (type 2 diabetes) is almost always present along with high blood pressure, high fat levels in the blood, cardiovascular disease, central obesity and abnormalities in blood clotting and inflammatory responses. It increases your risk of developing heart disease (heart attack, stroke, etc.) and diabetes. Being overweight or obese, not getting enough exercise and genetic factors increase your risk of developing metabolic syndrome. Women also have specific circumstances like pregnancy, polycystic ovary syndrome (PCOS), use of oral contraceptive and menopause, which increase their chances of developing metabolic syndrome. Gestational diabetes during pregnancy and PCOS increases the likelihood of developing insulin resistance, a risk factor tied to the disorder. Women who have had gestational diabetes or who have had a heavy baby are at higher risk for developing type 2 diabetes later in life.

Formal healthcare

The formal healthcare setup in India is huge and diverse. Sectoral plurality and functional diversities mark the provisioning of healthcare in the country. The privileging of the biomedical model in medical colleges across the country reflects in various ways, ranging from textbooks that are often gender blind/ insensitive to providers' attitudes that may display lack of understanding of socioeconomic causes underlying ill health. The public sector has a considerable and diverse physical presence, largely owing to the gains made prior to the 1990s. The public healthcare infrastructure ranges from a sub-centre in a village to multi-specialty, multi-bedded hospitals in urban areas. Primary Health Centers, Rural Hospitals, Civil Hospitals as well as a host of facilities like municipal hospitals and clinics are some of the other public healthcare facilities. The state may also run health facilities dedicated to specific diseases (for example, leprosy clinics) or specific population sub groups (for instance, Central Government Health Scheme). The structure of the public health sector is

thus fairly well defined. In the 1990s, there has been uneven growth in the number of Community Health Centres (CHCs), Primary Health Centres (PHCs) and Subcenters (SCs) in the different states and union territories of India. While some states have witnessed considerable increase in such facilities, the progress has been very slow or stagnant in others. For the country as a whole, tribal areas are deficient in the three types of public facilities set up for providing primary healthcare, the deficiency being severe for Community Health Centres. Barring a few states and union territories, the others have deficiencies in the three types of public facilities.

CONCLUSION

Women's empowerment is hindered by limited autonomy inmany areas that has a strong bearing on development. Their institutionalised incapacity owing to low levels of literacy, limited exposure to mass media and access to money andrestricted mobility results in limited areas of competence and control (for instance, cooking). The family is the primary, if not the only locus for them. However, even in the household domain, women's participation is highly gendered. Nationally about half the women (51.6%) are involved in decision making on their healthcare. Women's widespread ignorance about matters related to their health poses a serious impediment to their well-being. The NFHS-2, for example, reports that out of the total births where no antenatal care was sought during pregnancy, in 60 percent of the cases women felt it was 'not necessary'. And, at a time when AIDS is believed to have assumed pandemic proportions in the country, 60 percent of the ever married women have never heard of the disease. Women's inferior status thus has deleterious effects on their health and limits their access to healthcare. The household has been seen to be a prominent site for gender based discrimination in matters of healthcare in a number of other studies too. Marriage in India is predominantly patrilocal with the new bride relocating to her marital house after marriage. Early marriage usually follows a truncated education, disadvantaging girls in many ways. In such a setup, the new bride, already ignorant about health processes, may be in a difficult position to seek healthcare. Basua and Kurz report from their study on married adolescent girls in Maharashtra that 'girls had neither decision making power nor influence' in matters relating to seeking healthcare for their problems7. These illnesses that incapacitated girls from discharging their household responsibilities were treated quickly.
The culture of silence prevented care seeking in problems related to sexual health. Some reproductive health problems went untreated because they were considered 'normal'. Girls in India are discriminated against in other ways as well – fewer months of breastfeeding, less nurturing and play, less medical treatment if they fall ill, less special food, less prenatal attention. As a result, girls are far more susceptible than boys to disease and infections, leading to poor health and a shorter lifespan. It is this lifelong discrimination in nurturing and care that is the real killer of girls, less visible and less dramatic, but as unequivocally lethal as female foeticide and infanticide (UNICEF, 1998).As UN Secretary Kofi Anan had stated, "Gender equality is more than a goal in itself. It is a precondition for meeting the challenge of reducing poverty, promoting sustainable development and building good governance."This recognition is currently missing in India. Transforming the prevailing social discrimination against women must become the top priority. This must happen at war footing before it gets

very late to improve the social and economic status of women. In this way, a synergy of progress can be achieved. As women receive more education and training, they will earn more money. As women earn more money - as has been repeatedly shown - they spend it in the further education and health of their children, as opposed to men, who often spend it on drink, tobacco or other women. As women rise in economic status, they will gain greater social standing in the household and the village, and will have greater voice. As women gain influence and consciousness, they will make stronger claims to their entitlements -gaining further training, better access to credit and higher incomes - and command attention of police and courts when attacked. As son preference declines and acceptance of violence declines, families will be more likely to educate their daughters, and age of marriage will rise. As women are better nourished and marry later, they will be healthier, more productive, and will give birth to healthier babies. Only through action to remedy, discrimination against women can be eradicated, which was the vision of India's Independence - an India where all people have the equal chance to live, attain healthy and productive lives - be realized. No policies or campaign would be successful without public support, awareness and proper implication. There is a need to raise the voice against gender discrimination in health care facilities and to improve the status of women at the every possible level and should it not be stopped until and unless this problem is totally removed from the society.