The Health Status of Women in India

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The scientific community and the public have become increasingly aware of and justifiably concerned about the health of women and there is consequent increasing demand to evaluate the potential health risk factors of the women community. Health doesn't mean body/physical fitness it is actually over all wellbeing which includes mental and social fitness thus we can define health as "the measure of our body's efficiency and overall wellbeing".Every day, approximately 1000 women die due to complications of pregnancy and childbirth — nearly all of these deaths are preventable. Access to family planning is also known to play an important role in reducing maternal mortality. Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and nonpersonhealth services. Every year, 99% of maternal deaths occur in developing countries. Despite theincrease in contraceptive use over the past 30 years, significant unmet needs remain in all regions. Forexample, in sub-Saharan Africa, one in four women who wish to delay or stop childbearing does not useany family planning method. According to WHO, improving access, coverage and quality of servicesdepends on the key resources being available; on the ways services are organized and managed, and onincentives influencing providers and users. This article highlights some of the basic issues of the womencommunity in India and their remedies.

Genderbiasinaccesstohealthcare

The United Nations ranks India as a middle-income country. Findings from the World Economic Forum indicate that

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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 many social determinants of health—which include social, economic, and political factors— that play a major role in the health outcomes of women in India. Therefore, the high level of gender inequality in India negatively impacts the health of women.

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.

The low status of—and subsequent discrimination against—women in India can be attributed to many cultural norms. Societal forces of patriarchy, hierarchy and multigenerational families contribute to Indian gender roles. Men use greater privileges and superior rights to create an unequal society that leaves women with little to no power. This societal

structure is exemplified with women's low participation within India's national parliament and the labour force.

Women are also seen as less valuable to a family due to marriage obligations. Although illegal, Indian cultural norms often force payment of a dowry to the husband's family. The higher future financial burden of daughters creates a power structure that favors sons in household formation. Additionally, women are often perceived as being incapable of taking care of parents in old age, which creates even greater preference for sons over daughters.

Taken together, women are oftentimes seen less valuable than men. With lower involvement in the public sphere—as exemplified by the labour and political participation rates—and the stigma of being less valuable within a family, women face a unique form of gender discrimination.

Gender inequalities, in turn, are directly related to poor health outcomes for women. Numerous studies have found that the rates of admission to hospitals vary dramatically with gender, with men visiting hospitals more frequently than women. Differential access to healthcare occurs because women typically are entitled to a lower share of household resources and thus utilise healthcare resources to a lesser degree than men. access to fewer household resources to their weaker bargaining power within the household. Furthermore, it has also 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.

Cooperative conflicts approach to gender biases

cooperative conflicts approach to gender biases frames women's gender disadvantage through three different responses: breakdown wellbeing, perceived interest and perceived contribution responses. The breakdown well-being response derived from the Nash equilibrium describes breakdown positions between individuals during cooperative decisions. When the breakdown position of one individual is less than the other person, the solution to any conflict will ultimately result in less favourable conditions for the first individual. In terms of women's health in India, the overall gender disadvantage facing women represented by cultural and societal factors that favour men over women negatively impacts their ability to make decisions with regards to seeking out healthcare.

The perceived interest response describes the outcome of a bargained decision when one individual attaches less value to his or her well-being. Any bargaining solution derived between the aforementioned individual and another individual will always result in a less favourable outcome for the person who attaches less value to their well-being. The health status of women in India relates to the perceived interest response because of the societal and cultural practices that create an environment where the self-worth of women is marginalised compared to men. Therefore outcomes relating to healthcare decisions within households will favour the men, due to greater self-worth.

The perceived contribution response describes the more favourable position of an individual when the individual's contribution is perceived as contributing more to a group than other individuals. The more favourable perception gives the individual a better outcome in a bargaining solution. In terms of women's health in India, males' perceived contribution to household productivity is higher than that of women, which

ultimately affects the bargaining power that women have with regards to accessing healthcare.

Problems with India's healthcare system

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 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.[16] 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.[16] 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 (NHRM). 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.[18] 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.

Malnutrition and morbidity

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 isgender 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.

Poverty and malnutrition are common issues faced by Indian 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.[22] 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.[23] As of 2012, India has a shortage of trained oncologists and cancer centres, further straining the health care system.[22]

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.

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.[33] 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 relationship 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.[7] 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.

Suicide

Indian women have higher rates of suicide than women in most developed countries. Women in India also have a higher rate of suicide compared to men. The most common reasons cited for women's suicide are directly related to depression, anxiety, gender disadvantage and anguish related to domestic violence.

Many of the high rates of suicide found across India and much of south Asia have been correlated with gender disadvantage. Gender disadvantage is often expressed through domestic violence towards women. The suicide rate is

particularly high among female sex workers in India, who face numerous forms of discrimination for their gender and line of work.

Domestic violence

Domestic violence is a major problem in India. Domestic violence acts of physical, psychological, and sexual violence against women is found across the world and is currently viewed as a hidden epidemic by the World Health Organisation. The effects of domestic violence go beyond the victim; generational and economic effects influence entire societies. Economies of countries where domestic violence is prevalent tend to have lower female labour participation rate, in addition to higher medical expenses and higher rates of disability.

The prevalence of domestic violence in India is associated with the cultural norms of patriarchy, hierarchy, and multigenerational families. Patriarchal domination occurs when males use superior Women who are in the labour force in India often face greater risk of being the victims of domestic violence rights, privileges and power to create a social order that gives women and men differential gender roles. The resultant power structure leaves women as powerless targets of domestic violence. Men use domestic violence as a way of controlling behaviour.

In a response to the 2005-2006 India National Family Health Survey III, 31 percent of all women reported having been the victims of physical violence in the 12 months preceding the survey. However, the actual number of victims may be much higher. Women who are victimised by domestic violence may underreport or fail to report instances. This may be due to a sense of shame or embarrassment stemmingfrom cultural norms associated with women being subservient to their husbands. Furthermore, underreporting by women may occur in order to protect family honour.

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