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Women and Health

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Indian society has always recognized the need for special considerations for women in its traditional aspects. Earliest treaties, in Charaka Samhita believed to have been composed in the 5th Century B.C. It contains special sections on women's health and how to treat their specific medical problems.

Women health is the branch of medicine focuses on the treatment and diagnosis of diseases and conditions that effect a women's physical and emotional well-being. Women health includes a wide range of specialties and focus area such as Birth control, sexually transmitted infections and gynecology and other female cancer, mammography, menopause and hormone therapy, osteoporosis, pregnancy and child birth, sexual health, women and heart disease, functions of the female reproductive organs.

Women health refers to the health of women which 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 of 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 risk and experiences are for the disadvantaged. 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.

The early planners of our health system wanted to extend the benefits of Western medical science to women and children living in village through establishing Women Welfare Centers.

At the end of the 20th Century, where we look at the scenario of availability of health care facilities for women, if we compare the life expectancy with other countries Indian female have 63.3% expectancy rate when compared to Canada (81.9%), France (82.1%), U.S.A. (80.2%) and China (72.3%) has more.

Traditionally in Indian society the mother has always been referred as the giver of life, nurturer of children and "Matrishakti" or maternal feelings are considered a force to be reckoned with in girls. It has always been considered essential for a woman's growth, development and states in society that she should become a mother. The worst sin in Indian society is to be born a woman who is incapable of giving birth. Indian women have regardless of their health, always tried to bear children and even now 28 million women conceive children every year out of which 25 million live births occur.

The health of a woman would depend very much on her nutritional states during adolescence and the general growth pattern of her body. Nutritional status of most Indians is inadequate in some essential nutrition requirements like energy, protein, iron and vitamins, A & B complex. No national nutrition survey has been attempted but State Directorates of Health have been carrying on such surveys from before Independence. Women are seen to be suffering from iron deficiencies. Many state level surveys on anemia have indicated its prevalence among men and women.

Another harmful factor in womens nutrition during pregnancy is the location of a previous child. Nearly one-third pregnancies occur to lactating mothers. Some women stop breast feeding when pregnancy occurs. But if they continue it has very harmful effects on her nutritional states.

An important revelation of the recent studies is that employment of women in urban areas leads to improved financial states in urban high and middle income groups and improved maternal nutrition states among lower middle class income groups as well as prevention of deterioration in the nutrition states of low income poverty groups.

The maternal mortality rates are higher in the 15-19 years age group for understandable reasons of low health status, lack of knowledge about pregnancy and other related problems. The maternal mortality rates of India are very high compared to the developing countries of the West and East Asia. India has itself committed to the latest United Nation's targets for the Sustainable Development Goals (SDGs) for MMR at 70 per 100,000 live births by 2030 as per NHP (National Health Policy). In 2017 the target for MMR is 100 per 100,000 live births by 2020. The maternal mortality rate (MMR) in India has declined to 113 in 2016-18 from 122 in 2015-17 and 130 in 2013-14. According to the Special bulletin on Maternal Mortality in India, from 2016-18 Assam had the highest MMR in the country followed by Uttar Pradesh (197) and Madhya Pradesh (173) and Kerala reported the lowest MMR (43) followed by Maharashtra (46) and Tamil Nadu (60) respectively. Karnataka's MMR declined by five points from 97 per 100,000 in 2015-17 to 92 in 2016-18. Karnataka's ranking has been improved from 11th to 9th position in the country.

An important question which arises is that does a woman have the right to decide whether she wants to be a mother or not, as majority of women are expected to marry as an arrangement of families the choice of being a mother is left generally to the husband's family. Many young women have no desire to be mother soon after their marriage.

Immunizations of pregnant women have been started in the 70's under the expended program of immunization. Protection from anemia through the distribution of iron and folic acid was started in 1973. Supply of equipments for management of emergencies has also always been the aim of the Governments. Now everything is managed under their programme whose name has further been changed to Reproductive Health Programme in 1997.

Women do not have health problems relating to their biological function of child bearing. Due to reasons of poverty women are not able to go through their menstrual function with safe and clean sanitary pads. Usually old and dirty clothes are used for the purpose leading to reproductive health problems. The lack of water and extreme inadequacy of clothing available with girls and women in the poorest strata further contributes to their ill health due to lack of personal hygiene.

Women are also exposed more to rheumatism through exposure to water and parasitic like Malaria and insect bites through agricultural labour. Some women are more disadvantaged than others. Women belonging to the 20% of the population falling below the poverty lines get even less food than the others. They need to be given extra health care. Similarly women who head households either because they are deserted by their husbands or are widows require special attention to their health states.

The scenario for womens health though it has improved since independence as indicated by their long life expectancy is far from satisfactory. As far as reproductive health and family planning are concerned the Population Education programmes started in schools and colleges have to be extended to the public in a very big way. Knowledge about sex and contraception has to be a part of the curriculum all institutions of education as well as the work place, Mahila Mandals and part of the obligations of women's voluntary organizations working in any sphere of women's development.

Where women are the main acceptors of contraceptives, greater privacy, dignity and humanity have to be introduced. Women have to be treated with greater respect and given a choice of methods. Sterilization has to be done carefully and after due selection of pre-operative cases. Greater care during surgery by way of skilled surgeons and anesthetists still require to be emphasized. Safe delivery whether you term it in the safe motherhood programmes or the Reproductive Health Programme is the birth right of every woman.

For women to be active receivers of health care, a life cycle approaches from cradle to the grave has to be initiated. Women have to be trained to demand access to hospitals. There is no disaggregated data available about women receiving treatment under the National Health Programme like malaria, tuberculosis, blindness cataract, AIDS, leprosy or STD infections.

It is also important that women be trained to demand access to the health care. They are usually the last ones to go to health centers for treatment for themselves though they may take their family members and children. They do not give importance to their health because of low self-esteem. Voluntary efforts in sensitizing women to the need for looking after their health is necessary. Women should demand and must get access to health services.

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