UNIT 9: WOMEN AND HEALTH

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9.1 LEARNING OBJECTIVES

After going through this chapter you will be able to

- know the Health status of women in India
- understand mortality and morbidity factors influencing health
- know the concept of HIV and AIDS control program
- understand National health and Population Policies and Programmes.

9.2 INTRODUCTION

Women and Health is a comprehensive reference which addresses health issues affecting women of all ages. There are multiple issues that are related to health and women.It covers important key issues which ranges broadly from osteoporosis to breast cancer and other cancers, domestic violence, sexually transmitted diseases, occupational hazards, eating disorders, heart disease and other chronic illnesses, substance abuse, and societal and behavioral influences on health.Women and Health covers not only those conditions that are unique to or occur more frequently in women, but also those that present differently or are treated differently in women.

Moreover , health is considered, in all respects, physical and mental, as a fundamental human right. It is basically the basis for well-being and participation in many aspects of life. Biology influences health, but so do society's social norms, political choices and levels of economic advancement—all of which contain patterns of gender discrimination. Thus, this means that full health eludes most women in the world today.Discrimination bars some from accessing the health care services they need, or renders them more susceptible to illness. Gender-based violence, a persistent epidemic in all societies, destroys women's physical and mental health, and at times takes their lives.

9.3 HEALTH STATUS OF WOMEN IN INDIA

Why there is focus on women and health? The major reason is that women and girls have particular health needs and that health systems are failing them.There are certain conditions that only women experience and that have negative health impacts that only women suffer. Conditions, such as pregnancy and childbirth, are not in themselves diseases, but normal physiological and social processes that carry health risks and require health care.

Some health challenges affect both women and men but, because they have a greater or different impact on women due to biological process, they require responses that are tailored specifically to women's needs. Women may have faced greater difficulties in getting the health care they need. Furthermore, gender-based inequalities – as in education, income and employment – limit the ability of women to protect their health and achieve optimal health status.

Women's health matters not only to women themselves but it is also crucial to the health of the children or the future generations they would bear. This underlines an important aspect: paying due attention to the health of girls and women today is an investment not just for the present but also for future generations. This also implies addressing the underlying important social and economic determinants of women's health – including education,

which directly benefits women and is important for the survival, growth and development of their children.

Analyses of women's health is not a consistent phenomenon and often focus on, or are limited to, specific periods of women's lives (the reproductive ages, for instance) or specific health challenges such as the human immunodeficiency virus (HIV), maternal health, violence, or mental ill-health. There are certain health concerns that must be addressed urgently if girls and women are to realize fully their human right to health and, by extension, to their economic and social rights.From this overview of the burden of ill-health, women face at different ages – not only deaths but also non-fatal, often chronic conditions. The socioeconomic and gender-based inequalities that women face are played out in their access to and use of health care services. Poorest women are generally least likely to use health-care services. The reasons are various and complex: services may be unavailable or inaccessible, or women may be unableto find affordable transport. In some context sociocultural norms also often limit women's mobility and interaction with male health providers. The way socioeconomic inequality plays out in different settings is important for determining the most effective policy and programme responses. In some settings, barriers to access to health care affect all households except the wealthiest. In India, besides Indonesia and Pakistan, while access to health services is better across all income groups, the wealthiest benefit most and poorer households are left behind. These different patterns of inequality imply the need for different programmatic interventions that range from targeting the poorest to strengthening the whole health system,to a combination of both strategies.

It is a paradox that health services are so often inaccessible to women community or unresponsive to their various needs given that health systems are so highly dependent on women. Women are the main providers of care within the family and constitute the primary backbone both of the formal health workforce and of informal health-care provision. Women predominate in the formal health workforce in many countries.

Female health workers face several work-related health problems many times. Because there are more women in the health-care workforce,

women account for about two-thirds of all global hepatitis B and C infections and HIV infections due to needle stick injuries. Women are also prone to musculo skeletal injuries (caused by lifting) and burn-out. Also female health workers are exposed to hazardous drugs that are mutagenic and possibly carcinogenic, and to chemical hazards such as disinfectants and sterilants which cause asthma, as well as to adverse reproductive outcomes such as spontaneous abortion and congenital malformations. Female community health workers may also be subjected to to different form of violence ranging from mental to physical.

9.4 MORTALITY AND MORBIDITY FACTORS INFLUENCING HEALTH

India is a diverse country where health is an important issue.Socio-cultural differences also lead to different access to health facilities.Death is caused both by communicable and non-communicable disease. However, non-communicable diseases are the leading causes of death in the country, constituting 42% of all deaths. Moreover, communicable, maternal, perinatal and nutritional conditions constitute another 38% of deaths. Injuries and ill-defined causes constitute 10% of deaths each. However, there is a contextual aspect to understand mortality and morbidity factors. Majority of ill-defined causes are at older ages (70 or higher years) and in many context most of ill-defined deaths are likely to be from non-communicable diseases.

Among the countries, India contributes to one-fifth of the global burden of absolute maternal deaths.However, it has experienced an estimated 4.7% annual decline in maternal mortality ratio (MMR), and 3.5% annual increase in skilled birth attendance since 1990 .India is making progress in reducing maternal mortality , but yet it is not on track to meet Millennium Development Goal number 5.

Within India, however there is a marked variation in MMR and healthcare access between regions and in socioeconomic factors .Different socio demographic factors are responsible beside the medical factors for this high ratio. Government of India from time to time has taken many steps for the improvement of health of pregnant and nursing women and women

in reproductive age group. But, the outcome is not satisfactory enough as far as the maternal mortality ratio is considered. Early age of marriage among women, early age of pregnancy, high birth rates, and less spacing between two deliveries are some social factors which cause increase in maternal mortality ratio. Beside these, high rate of malnutrition among women is also considered to be a social problem. On the other hand, there are medical conditions, like ante-partum hemorrhage, post-partum hemorrhage, anemia, eclampsia, ectopic pregnancy, rupture uterus also form a significant proportion of maternal mortality ,but most of these are preventable.In order to address such issue Indira Gandhi Matritva Sahyog Yojana (IGMSY), Conditional Maternity Benefit (CMB) is a scheme sponsored by the national government for pregnant and lactating women age 19 and over for their first two live births. The programme, which began in October 2010, provides money to ensure good health and nutrition of the recipients. So far, the programme is being offered in 53 districts around the country.

There is a disparity in access to maternal care between rural and urban populations.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. For the holistic improvement of health of mothers in India, different strategies are being taken since a long time. For the betterment of pregnant mothers,Government of India has launched reproductive and child health programme II (RCH-II) from 1st April, 2005.Further, Janani Suraksha Yojona (JSY) scheme has also been started on 12th April, 2005 for pregnant ladies.Moreover, National Population Policy 2000 and National Health Policy 2002 aim at reducing the Maternal Mortality Rate (MMR) to 100 per 100,000 live births from the current level of 400-500.

In the year, 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. The NHRM also 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 given the context.

9.5 NUTRITION AND HEALTH

Food plays an important role in health as well as in disease. With the current increase in lifestyle disorders, it is important to promote healthy nutrition in all age groups.

National Family Health Survey-3 indicates that 35.6 per cent of Indian women are chronically undernourished, with Body Mass Index (BMI) lesser than the cut off point of 18.5. Moreover, data from Bihar and Madhya Pradesh shows that girls represent up to 68 per cent of the children admitted to programmes for the severely malnourished. Children from scheduled tribes community have the poorest nutritional status on almost every measure.

Another initiative is Integrated Child Development Scheme (ICDS)which has been instrumental in improving the health of mothers and children under age 6 by providing health and nutrition education, health services, supplementary food, and pre-school education. ICDS is run by India's central government under the Ministry of Women and Child Development, targeting rural, urban and tribal areas.

Some of the most common nutritional problems of public health importance in India are low birth weight, protein energy malnutrition in children, chronic energy deficiency in adults, micronutrient malnutrition and diet related non-communicable diseases. In recent times the India Health Report: Nutrition 2015 surveys the trends in maternal and child under nutrition in India. It looks at various trends and disparities its outcomes across geographical regions, socio-economic classes, and demographic groups. In order totackle under nutrition and enabling improvements in the determinants of poor nutrition it requires actions from multiple actors and sectors, and at multiple levels .

9.6 HIV AND AIDS CONTROL PROGRAM

In medical terminology the human immunodeficiency virus (HIV) is a lentivirus (a subgroup of retrovirus) that causes HIV infection and over

time become acquired immuno deficiency syndrome (AIDS). In many regions, social context increase the risk of HIV infection making it difficult to tackle the global HIV epidemic effectively.Certain groups of people are more affected by HIV than others. Sometimes this could be because they engage in high-risk behaviours, while others experience stigma and discrimination that stops them from approaching HIV services. HIV is a virus that attacks the immune system. If untreated, a person's immune system will eventually be completely destroyed and gradually may lead to death.

The National AIDS Control Programme (NACP), launched in 1992, is being implemented as a comprehensive programme for prevention and control of HIV/ AIDS in India. Over time, the nature of focus has shifted from raising awareness to behaviour change, from a national response to a more decentralized response and to increasing involvement of Non-governmental Organisations (NGOs) and networks of People living with HIV (PLHIV).

First phase of the NACP I started in 1992 was implemented with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country.In November 1999, the second phase of National AIDS Control Project (NACP II) was launched to reduce the spread of HIV infection in India, and (ii) to increase India's capacity to respond to HIV/AIDS on a long-term basis.

Third phase of NACP III was launched in July 2007 with the goal of Halting and Reversing the Epidemic over its five-year period.NACP IV, which was launched in 2012, aims to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well defined integration process over the next five years.

9.7 NATIONAL HEALTH AND POPULATION POLICIES AND PROGRAMMES.

The Constitution of India makes health the responsibility of the state governments, rather than the central federal government. It makes every state responsible for "raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India

in 1983 and later updated in 2002. The National Health Policy has been reviewed in 2017 and a draft for public consultation has been released. There are great inequalities in matters of health between states. As per Census survey infant mortality in Kerala is 12 per thousand live births, but in Assam it is 56.

India launched its first family planning programme in 1951 as part of the First Five-Year Plan, and became the first country in the world to have a state-sponsored population programme. Family planning was recognised officially in order to safeguard the health and welfare of mothers and children. The programme was also aimed at aiding the national economy by reducing the birth rate concurrently with the death rate in order to stabilise the population. Several important policy decisions such as the 1976 population policy and action was initiated to give the family planning programme a greater thrust and a new direction. During the emergency period (1975-77), the methods of coercion and pressure were used in implementing the family planning programme. The central assistance of 8 per cent was linked with the family planning performance. In 1977, the new government ruled out the use of force and coercion, and the family planning programme was renamed as the 'family welfare programme'.

During the Sixth Five-Year Plan (1980-85), population control was specifically mentioned as one of the plan objectives, and was later integrated in the twenty-point programme.After the Seventh Plan (1985-90) was finalised, a revised strategy was adopted for the family planning programme. It emphasised on increasing the minimum age for marriage of women, by making them literate, enhancing their status by increased economic and employment "opportunities, improving the health of mothers and children, greater coordination and linkages with poverty alleviation programmes and greater involvement of the NGOs in the family planning programmes.Under the Eighth Plan (1992-97), human development was adopted as the ultimate goal and population control was listed as one of the priorities. Further plans prescribed different measures to address population issues.

Some of the measures considered to Control Population Growth by Government of India are:

The National Population Policy 2000 gave a focused approach to the problem of population stabilization. Further the National Commission on Population was formed in the year 2000. The Commission, chaired by the Prime Minister, has the mandate to review, monitor and give directions for implementation of the National Population Policy.

The Jansankhya Sthirata Kosh (National Population Stabilization Fund) was setup as an autonomous society of the Ministry of Health and Family Welfare in 2005. Its broad mandate, however, is to undertake activities aimed at achieving population stabilization.

Programmes like the National Rural Health Mission, JananiSurakshaYojana, ICDS (Integrated Child Development Services) etc. have also been launched by the government to tackle the healthcare needs of people from time to time. Such measures are also expected to contribute to population stabilization.



CHECK YOUR PROGRESS

12.7.1 Fill in the blanks

a. The National Health Policy was endorsed by the Parliament of India in _____ and updated in 2002.

b. The National Population Policy 2000 gave a focused approach to the problem of _____.



9.8 LET US SUM UP

- Good and progressive health is a key criterion, which contributes to humanwellbeing and economic growth.
- Adequate nutrition in a consistent manner for womenwould help them to serve as productive members of the societyto develop the consequent health generations.
- The governmentshould take necessary and compulsory policies in a systematic manner to improve theliteracy rate and quality education as well as to provide adequateemployment opportunities

for women, which might explorepositive impact on the women's health concerns.

- The governmentcan also improve the health status of women by strengtheningand expanding essential health services gradually as well as by frequentcounselling on safe sex, awareness on educational and nutritionalneeds and gender based violence.



9.9 FURTHER READING

1) Sarojini N.B, ChakraborthySuchita, VenkatachalamDeepa, Bhattacharya Saswati, Kapilasharmi

1) Anuj and Ranjande (2006)"*Women's Right to Health"*, – National Human Rights Commission,New Delhi.

9.10 ANSWER TO CHECK YOUR PROGRESS



a. 1983

b. population stabilization.



9.11 MODEL QUESTIONS

A) Write Short notes (Answer within 150 words)

1.What is mortality and morbidity?

B) Long type questions (Answer within 300-500 words)

1. Explain HIV and AIDS.

2. Explain Population Policies

3. Who is the relationship between nutrition and health? Explain