Women's Health in India

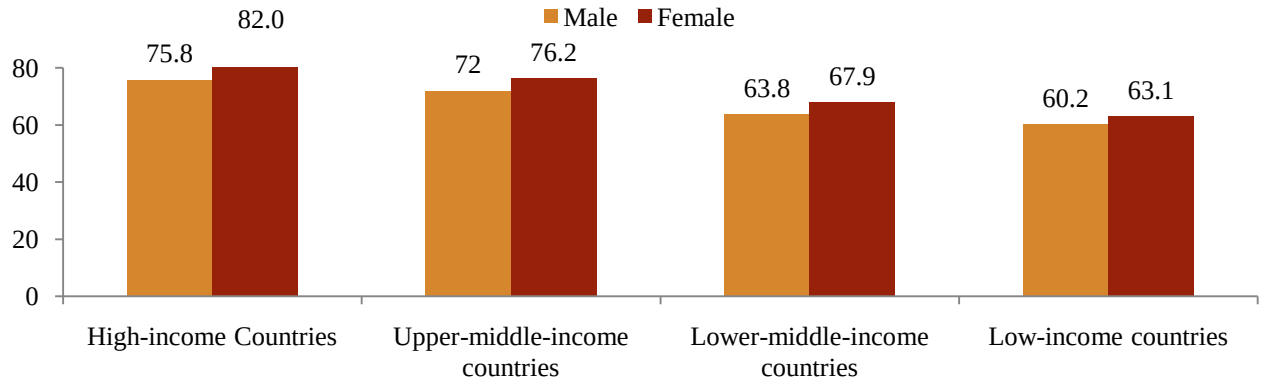
This report aims to address the common health issues that affect women and challenges faced in accessing quality health care. Relevant strategies for tackling these health issues and challenges have been mentioned.

Current Status of Women's Health in India

According to the World Health Organization, due to biological differences women live longer than men in all regions of the world. The difference is wider in high-income nations. India, listed as a low-middle income country, records a difference of 3 years between life expectancy at birth for women and men. India ranks 141, above only Armenia, on the health index in World Economic Forum's *The Global Gender Gap Report 2014*, which benchmarks gender gaps in 142 countries on economic, political, education and health-based criteria.

Country	Health and Survival Rank
Indonesia	58
Pakistan	119
Bangladesh	122
India	**141**

Life expectancy at birth in 2012, by country income group



Common Health and Survival Issues Faced by Women in India

Indian women face a host of issues around healthcare which are intrinsically linked to their status in society. This brief focuses on key issues of nutritional status, reproductive health and unequal treatment of girls and boys which affect women most deeply.

1. Malnourishment

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. 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. Similarly, 55 % women in India are anemic as compared to 24% of men.

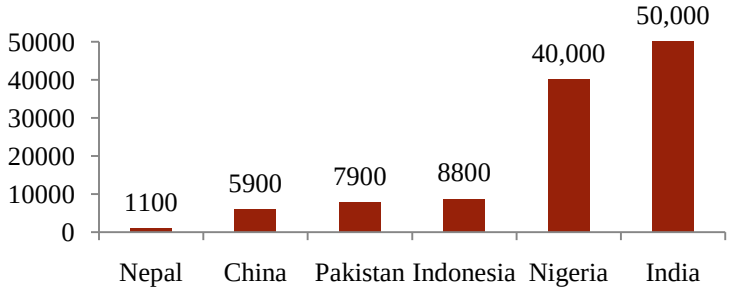
Widespread nutrition deprivation among women perpetuates an inter-generational cycle of nutrition deprivation in children. Undernourished girls grow up to become undernourished women who give birth to a new generation of undernourished children. Maternal malnutrition has been associated with an increased risk of maternal mortality and also child birth defects.

Age	Mean Body Mass Index (BMI)	Body Mass Index (BMI) in kg/m2			
		18.5-24.9 (normal)	<18.5 (total thin)	17.0-18.4 (mildly thin)	<17.0 (moderately/ severely thin)
15-19	19.0	50.8	46.8	25.9	20.9
25-29	20.0	53.7	38.1	21.7	16.4
30-39	21.1	51.6	31.0	17.0	14.0
40-49	21.9	49.8	26.4	14.1	12.3
TOTAL	**20.5**	**51.8**	**35.6**	**19.7**	**15.8**

2. Maternal Health

India's Maternal Mortality Rate (MMR), the number of women who die from pregnancy-related causes per 100,000 live births, stands at 190. As a result, India accounts for the maximum number of maternal deaths in the world — 17 per cent or nearly 50,000 of the 2.89 lakh women who died as a result of complications due to pregnancy or childbearing in 2013.

Number of Maternal Deaths, 2013



Assam has the highest maternal deaths with a MMR above 300. Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhatisgarh, Orissa and Rajasthan also record MMRs above the national average. The leading causes of maternal death are haemorrhage, sepsis, abortion, hypertensive disorders, obstructed labour and other causes, which include anaemia.

3. Female Child Mortality

In India, female infant mortality is slightly higher than male infant mortality, but the survival disadvantage of girls is particularly acute in the age group of 1-6 years. The Child Sex Ratio, defined as the number of females per 1000 males in the age group of 0-6 years, has been on a declining trend. States/ Union Territories with extremely low child sex ratio are Haryana (830), Punjab (846), Jammu and Kashmir (859) and Delhi (866).

State	1991	2001	2011	Difference 2011-1991
India	**945**	**927**	**914**	**-31**
Uttar Pradesh	928	916	899	-29
Madhya Pradesh	952	932	912	-40
Rajasthan	916	909	883	-33
Maharashtra	946	913	883	-63
Haryana	879	819	830	-49

Declining Child Sex Ratio reflects the imbalance between the number of girls and boys and points towards both, pre-birth discrimination manifested through gender biased sex selection, and post birth discrimination against girls. Several reasons are attributed to the decline in the number of girls – neglect of the girl child, high maternal mortality, female infanticide and female foeticide. Sex-selective abortions have been greatly facilitated by the misuse of diagnostic procedures such as amniocentesis that can determine the sex of the foetus.

Illiteracy, low socio-economic status, early age of marriage, poor sanitation, hygiene and nutrition, poor access to health facilities are also contributing factors of child and maternal mortality.

Strategies to Improve Health and Survival Outcomes:

Three strategies have been outlined which focus on improving access and quality of healthcare and awareness amongst women. Each of these solutions has been discussed through approaches and cases below.

1. Tele-medicine: Answering Medical Needs Using Remote Technology

Telemedicine is rapid access to remote medical expertise through telecommunication and information technology. It reduces the cost of service delivery and improves healthcare access. Owing to the shortage of doctors and hospitals in rural areas, telemedicine solutions have become an attractive option. Telemedicine allows patients to have direct interaction with specialist doctors, which may be situated in far off locations. With increasing internet penetration, telemedicine can be leveraged to increase health access.

Telemedicine is a fast-emerging sector in India; several major hospitals have adopted telemedicine services and entered into public-private partnerships (PPPs). In 2012, the telemedicine market in India was valued at $7.5 million; it is projected to rise to $18.7 million by 2017.

Tele-medicine Social Franchising in Rural Uttar Pradesh

World Health Partners (WHP) established 116 telemedicine clinics (SKY Clinics) providing health services mostly to reproductive age women from 1293. Through live streaming audio/video internet connections, the villagers consulted with physicians located elsewhere in India and experienced greater access to quality health services and contraception. The SKY Clinics were operated as a social franchise by female rural health practitioners (RHP) who profited from the consultation fees and drug sales. Using ReMeDi (a tele-medicine gadget), the RHPs measured blood pressure, temperature, heart rate, respiratory rate, and could assess EKGs with the results directly transmitted to the physician. Access to quality reproductive health services and contraception dramatically increased among the 6 million Uttar Pradesh villagers as a result of these social franchised telemedicine clinics.

2. Improving health care through community participation

The Rogi Kalyan Samiti (RKS) is an institution which allows for management of public hospitals through community participation. The concept originated in Madhya Pradesh and has now been institutionalized under National Rural Health Mission. RKS members include government officials, professionals, civil society organizations, as well as elected representatives (MPs and MLAs).

RKS enjoys financial autonomy in the form of untied grants under NRHM and can also generate its own revenues. Annual grant of Rs 1 lakh is provided to each primary health centre and community health centre. A district hospital is provided an annual grant of Rs 5 lakh. It is the responsibility of the RKS to ensure proper management of healthcare delivery, efficient running of medical equipment and overall monitoring of hospital services to ensure high quality.

Success of Rogi Kalyan Samitis in Madhya Pradesh

Rogi Kalyan Samitis have been set up in all districts of Madhya Pradesh. In over 450 hospitals user charges have been levied by the Rogi Kalyan Samitis. MPs and MLAs have also earmarked funds out of their discretionary local area development funds for improvement of health institutions. A total of Rs 35-40 crore has been collected through donations and user charges through these samitis. District Red Cross Societies have also been functioning in tandem with Rogi Kalyan Samitis.

Rogi Kalyan Samitis have led to improvement in hospital infrastructure across Madhya Pradesh. This includes maintenance and repair of existing equipment, purchase of new equipment, up-gradation of lab infrastructure, construction of OPD wards, as well as augmentation in basic infrastructure such as water supply and drainage. Management by RKS has led to improvement in efficiency of doctors, marked improvements in the conditions of medical institutions, and an increase in the number of patients coming to government hospitals.

As a result of the success of RKS, medical colleges in the state have been converted into autonomous bodies and the management handed over to the RKS.

3. Improving awareness and health care quality through partnership with NGOs

The National Health Policy lists partnerships with NGOs as an important, viable strategy for improvement in healthcare services. The government must partner with civil society on issues of policy formulation, planning, implementation, monitoring and evaluation, training and research. Under the partnership, both partners are equal stakeholders and collaborate equally on all aspects of a program. There are many NGOs working in the field of healthcare. They either work directly with target groups or create advocacy for reforms in healthcare.

Association for Social and Health Advancement (ASHA), West Bengal

ASHA is a non-profit, non-political, non-governmental organization which has been working to improve the socio-economic and health status of disadvantaged communities. ASHA works towards promoting primary health care and the reproductive and child health status of vulnerable communities following mixed approaches of behaviour change communication, and facilitating access to formal health service delivery structures. The main issues addressed include safe motherhood, essential newborn care, family planning management of reproductive tract infections/sexually tract infections, HIV/AIDS control and community participation.

The organization has developed location based health projects in 7 undeserved districts of West Bengal with capacity building of 18 other NGO partners. ASHA has implemented several health projects – initiative using a group approach to improve reproductive and child health status in the community under the National Reproductive and Child Health (RCH) project in Murshidabad and Bankura districts with support from the Government of West Bengal.ASHA has also been collaborating with Zilla Parishads and District Rural Development Cells under different schemes such as the Swarnajayanti Gram Swarojgar Yojana scheme and Swayamsidha Project under the West Bengal Women Development Undertaking under the aegis of the Department of Social Welfare of the State Government.