

Enabling holistic approach towards women's health through Draft National Health Policy, 2015

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The Government of India released the Draft National Health Policy, 2015 on 31 December 2014, which was placed in the public domain for comments, suggestions and feedback on the website of the Ministry of Health and Family Welfare (MoHFW)¹. The Draft aims at improving the overall health care delivery system in the country. It also seeks to improve upon the set outcome indicators related to women's health.

The Draft National Health Policy, 2015 is a comprehensive effort based on the review of earlier health policies (National Health Policy, 1983 and National Health Policy, 2002) which have been guiding the approach of the health sector in the country. The Policy has been formulated after a period of 13 years and the strategy is based on the recommendations given by the High-Level Expert Group (HLEG) set up by the erstwhile Planning Commission and several other consultations within and outside the Government, as well as a close review of the actual performance of the sector during the Eleventh Plan period².

The Draft Policy has made several positive commitments to address women's health issues, specifically to meet both national as well as international targets. These include commitments to attain the targets as the projected Millennium Development Goals (MDGs) with respect to maternal and child mortality in the country. The policy addresses key national health outcome goals that include reduction of maternal mortality ratio (MMR), and prevention and reduction of anaemia among women aged 15–49 years. However, there are several areas that need to be strengthened in the Policy keeping women's holistic health perspective in view.

This note looks at the Policy from the women's perspective using a life-cycle approach, particularly the need for considering their general or specific health needs along with reproductive roles (maternal health needs), based on the principle of gender equity, keeping in view the different needs of men and women. It is also important to understand that women are not a homogenous group (they include

young, old, widow, single, impacted by disasters (natural/manmade), rural/urban/remote areas/terrorist-prone and other difficult areas, victims of violence, disabled, including mental illness, homeless, SC/ST, backward classes and others belonging to vulnerable and marginalized communities with different requirements). They are at extreme periphery of health and social welfare policy and action³. Policy should be able to address all the specific needs of women who represent half the population of the country.

Beyond reproductive health care needs?

Women outlive men in most countries of the world, and for many health conditions, male mortality exceeds female mortality. Many policy makers and programme managers therefore remain unconvinced of any gender-based inequalities in health, and of the need for gender mainstreaming⁴. Similarly, other dimensions of gender inequality in health – such as in morbidity, access to health care and in social and economic consequences of ill health – are seldom examined. While the disadvantages experienced by women in sectors like education, employment or political participation are evident from available data, it is important to recognize that the case of health is more complex.

There is a need to use gender perspective in all health problems as well as in delivery of health care services with an understanding that there are differences between women and men with regard to health needs and experiences. Though focusing on maternal health is important, it is also imperative to identify and address other issues and challenges related to women's health; for example, increased attention to the early detection of breast and cervical cancer; recognition of violence against women as a health problem; efforts made to address women's mental health issues; attention to gender-specific factors in addiction, primarily relating to tobacco use; efforts related to nutrition and eating disorders; and initia-

tives to reduce the incidence of tuberculosis and malaria among women.

There has been a trend to limit women's health policies to only reproductive roles while not giving enough recognition to other priority health issues influencing them. Gender dimension of other diseases needs to be addressed, since it has different impact on men and women. In the present era, with higher 'out of pocket expenditure' that mostly constitutes private expenditure of health⁵, women are the last ones to get medical treatment. Besides, limited health data disaggregated by sex remain an impediment to effective policy making, resource allocation, monitoring and evaluation. There is need to address incidence of other health issues while understanding the specific vulnerability of women to diseases, and recommend for improving quality of service delivery, promote access and coverage of women/girls from a life-cycle perspective as envisaged in the National Policy for Empowerment of Women, 2001.

Incidence of other diseases among women

The foremost causes of diseases and deaths reveal that there are differences in the conditions experienced by women and men. While the average life expectancy for women continues to rise⁶, significant health disparities exist between different groups and there are worrying levels of risk factors responsible for causing prolonged illness, injury and premature death. In addition, much of the gain in women's life expectancy is being spent with disability and disease due to increased dependency and poor supportive measures. Inequalities exist with women experiencing more of the burden of disease and health problems⁷. Vulnerability of women with respect to health remains throughout their life cycle: childhood, adolescence, old age and the large population of middle-aged women. The social problems revolve around widowhood, dependency, illiteracy and lack of awareness about the policies and

programmes from which they can benefit. Women are more vulnerable to several diseases and require specific attention that should be addressed by health policy of the country⁸.

Today, diseases such as cancer, cardiovascular disease (CVD), chronic respiratory disease and diabetes are the leading cause of death in women globally, killing a staggering 18 million women each year⁹. These are no longer diseases of the rich and elderly, and are increasingly impacting women in developing countries during the prime of their life. India is facing a growing cancer epidemic among women, and increased incidence has been observed for cancer in the breast, cervix, uterus and urinary bladder, ovary, oral cavity, etc. with a large increase in the number of women with breast cancer. In India, the average age for developing breast cancer has undergone a significant shift over the last few decades. Breast cancer is now the most common form of the disease in most cities in India and second most common in rural areas¹⁰. Problems with India's health care infrastructure prevent adequate screening and access for women, ultimately leading to lower health outcomes compared to more developed countries. Shortage of trained oncologists and cancer centres, further limits access¹¹.

CVD is another contributor to female mortality in India. It often goes 'unrecognized' and remains 'under-treated'¹². Women are more prone to the risk of CVD, with the largest group of women at risk aged 35–44 years. CVD is the leading cause of death among women regardless of race or ethnicity, accounting for deaths of 1 in 3 women¹³. Women have higher mortality rates relating to CVD than men in India because of differential access to health care between the sexes. The reasons for the differing rates of access stem from social and cultural norms that prevent women from accessing appropriate care. For example, mental illness among Indian women is high compared to men; so also is depression.

Indian women who face poverty and gender disadvantage show 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 depression⁸.

In the case of Indian women, increasing longevity and risk factors such as low calcium intake, vitamin-D deficiency, sex inequality, early menopause, genetic predisposition, lack of diagnostic facilities and poor knowledge regarding bone health, have contributed towards the high prevalence of osteoporosis and fractures. The number of women with osteoporosis, i.e. with reduced bone mass and disruption of bone architecture is increasing in India¹⁴.

There are several other emerging issues that impact women such as infertility, reproductive cancers, morbidities such as prolapse and gender-based violence which need to be studied and addressed through policy. Special attention is required for women and girls with disabilities, who face additional challenges while accessing health care due to lack of appropriate services or lack of understanding and training, etc. Linkages between programmes within the health sector need to be strengthened, e.g. for TB, malaria, HIV and other health programmes in the country for the need of women¹⁵. Women's health needs incessant investment and a health policy responsive to the total health needs of all women in the country to achieve SDG3 (Sustainable Development Goal 3)-ensure healthy lives and promote well-being for all women.

Disclaimer. Views expressed in this paper are personal and not of the organization.

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