

Status of Women's Health in India: Issues and Concerns

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Abstract:

Health is an important aspect of a person's life directly influencing one's performance and capacity. Good health and nutrition supports overall development of a person including mental health. A person in good health gives his best contribution to his own growth, family and society at large. In India health is also an important dimension to understand women's status. The health of Indian women is conditioned by her social, cultural and economic status. The respective position of a women in her family, her financial status and economic independence and her cultural background prescribes her health, personal growth and social position. In this way health and socio-economic status of women is inextricably intertwined. To understand the performance of women in society the insight into her health and causes of such health patterns is essential to understand. Role of gender disparity in patriarchal social setting is also very significant in this vein. The present study attempts to understand the health issues, determinants and factors affecting women's health in India. Secondary data has been used in this study. The objective of the study is to present a thorough review of the health conditions of Indian women. The study highlights the indicators and determinants of women's health in India. It also provides an analysis of government policies and programs related to improving the health and nutritional status of women in India.

Keywords: Women, Health, Patriarchy, Gender Disparity, Government programs.

MAIN THEME

Healthy citizen is an asset to his family and society. A person in good health contributes to his family and society in a better way and for a longer time. In India, Good health is inevitable requirement irrespective of any gender. However in India, especially in rural areas, health and nutritional status of women of any age category is a matter of concern. Indian women face starker health disparity and systemic societal challenges compared to health of women in most western countries. Role of gender disparity very significant in this vein. Gender disparity is gender inequality which refers to unequal rights between male and female based on gender roles, which consequently leads to unequal treatment in life. (Paavani & Koti, 2019) Gender disparity affects the status of women negatively. Health is an important aspect which is related to gender disparity. Gender disparity leads to denial of health rights and access to adequate

information regarding health such as family planning, abortion, nutrition and other reproductive health information.

Understanding health indicators leads to a better insight into the health profile and patterns of women. Health indicators helps in assessment of individual and population health status and place a crucial role in healthcare and public health settings. (Sokoya et al., 2025) Health indicators are metrics which provides insight into the characteristic of a population or the performance of an individual including assessment of possible health risk factors. Women health indicators are female infant mortality, maternal mortality, female morbidity, nutritional status and reproductive health.

INDICATORS OF WOMEN HEALTH STATUS:

1. Infant mortality rate - Infant mortality rate refers to the probability of dying between birth and exactly one year of age expressed per 1000 live births. It is related to access to the healthcare facilities and lifesaving health interventions such as vaccination, infectious disease treatment, adequate nutrition, clean water and sanitation. The most common causes of infant mortality are premature delivery, complications during birth or infection such as pneumonia and sepsis. (*Infant Mortality Rate Definition and Guide*, 2024) The infant mortality rate of India in 2024 was 23 deaths for everyone 1000 live births. (*World Bank Open Data*, n.d.) It is higher for female infants.

2. Maternal mortality- According to World Health Organization, Maternal mortality is a death of a woman during pregnancy or within 42 years of termination due to causes related to our person by pregnancy. It is calculated as maternal death per 1 lakh live birth as per sample registration system (SRS) data. In the context of sustainable development goals, countries need to accelerate the decline of maternal mortality by 2030. SDG 3 includes a target of reducing the global MMR to less than 70 per 100000 births, with no country having a maternal mortality rate of more than twice the global average. (*Maternal Mortality*, n.d.) India's maternal mortality ratio is 93 per lakh live birth. (*India Witnesses a Steady Downward Trend in Maternal and Child Mortality towards Achievement of SDG 2030 Targets*, n.d.) Kerala has the lowest while Assam having the highest number of maternal mortality rate. It is high but decreasing significantly.

3. Female Morbidity- Female morbidity refers to the incidence or state of illness among women within a population. Female morbidity is a complex issue which is influenced by various factors such as socio- economic status, healthcare, culture and other contextual conditions. It is a significant indicator of women's health status. In India, girls and women have high morbidity. However, there is no reliable data regarding female morbidity in India.

4. Nutritional status - In India, girls and women have high morbidity and malnutrition. Various health problems are seen in Indian females which are related to malnutrition and inadequate knowledge. Various health issues related to reproductive tract infection, HIV-AIDS, stunted growth, anemia, diarrhea, miscarriage, osteoporosis, etc. are common among women in India.

5. Fertility and Reproductive health- Health and nutritional status interact with marriage and fertility outcomes. The total fertility rate in India has declined from 5.2 in 1971 to 2.1 in 2019.(Saggurti & Gupta, 2025) This decline can be attributed to the factors such as wider adoption of family planning, higher literacy rate and growing women's participation in labor force, decline in early marriages and rising trend of delayed marriage. There is a regional and social economic heterogeneity present in case of fertility and marriage age. Southern States and smaller union territories show earlier attainment of low fertility and higher marriage ages while states such as Bihar and Madhya Pradesh continue to exhibit early marriages and higher adolescent fertility. Additionally, rural urban differences and educational disparity also remain important factors in the case of reproductive health and marriage age of women in India.(Kumari, 2025). Indian women are increasingly getting predisposed to PSOS (Polycystic Ovary Syndrome) which impacts her reproductive and long term health.

6. Other Physical and Mental wellness – This results from various occupational conditions, cultural demands, personal incidents and other contextual conditions related to the women. It includes various occupational conditions which involve carrying heavy loads or working in smoky conditions. Also some work demands engaging in wrong postures which pose difficulty in future. Other conditions includes incidents of rape, domestic violence, postpartum depression, burning, beating and other physical assaults. It also includes mental stress and depression which may not be manifested overtly but affects the health of women.

DETERMINANTS OF WOMEN HEALTH:

The determinants of a person's health is a very complex one which involves various factors such as biological or genetic factors, social and cultural factors, psychological factors and the person's nutritional intake. Primarily, the patriarchal social structure of India and prevailing gender disparity is the main cause of neglected health of girls and women in India.

1-Social status-

In Indian patriarchal society, the social status of women is lower than men. The literacy rate of women is less than that of men. This affects not only the decision making capacity of a woman but also her awareness regarding health, family planning, nutrition and various diseases. (*Gender and Health*, n.d.)The lower social status and literacy leads to limited access to economic resources and money which ultimately determines her health. Similarly lack of autonomy and restricted mobility in the family leads to ignored health where a doctor is made available only when the condition becomes serious. It is seen that not every illness is seen as important enough to be consulted by a doctor. Unavailability of lady doctors results in the compromised health of women especially in rural areas. Women's access to health care services also varies across the class and caste lines. The condition is better in high caste and class families where women are educated, sometimes with greater mobility, thus increasing awareness and access to health care practices and services.

2-Economic status -

The social economic status of women is directly related to and affects the access to diet and health services. It also determines her literacy level and so the awareness regarding health and nutrition is also closely related to it. The disadvantages of social position related to low economic status results in unhygienic living conditions, more exposure to diseases and unavailability of nutritious food. Similarly, women's engagement in non-productive domestic chores, regarded as of lower economic value, prefers men's health over women, which again leads to the perpetuation of poor health. The bread winner status of men places them in an advantageous position from that of women with full access to resources, mobility and facilities. On the other hand, girls and women suffer from gender bias and neglect resulting in inadequate diet, early and frequent pregnancy and sometimes serious health conditions. Conditions of poverty and neglect result in delayed access to medical treatment, at more advanced and critical stages of disease, often turning fatal. There is a difference also in the healthcare facilities access of women of high and low class, with difference in their health status. Women working in the field and as domestic labour need more calories. But lower economic status denies nutritional food and proper calorie intake. Women of lower class in that reproductive period work late in their pregnancy with no rest and inadequate nutritional food. Inadequate knowledge and no say in decision making worsens the situation with repeated pregnancy in an already exhausted and nutrition depleted body. Later this results in premature birth and poor physical and cognitive development of the newborn child.

3-Education –

The lower rate of female literacy is linked to the social economic status of the girl child. It varies across the class lines where the girls from high class get comparatively better education with regard to girls belonging to lower class. This difference is extended after the marriage of the girl, where the mother and child health from the high class is better than the girl belonging to the lower class. Thus, an educated mother knows about her own health and takes better care of her child as compared to an uneducated or less educated mother. Similarly, awareness about health care services, family planning, nutrition, pregnancy related nutritional care, the child survival rate and cognitive ability of the child are also directly related to the knowledge and education of the women. When denied the basic right of education, a woman has few chances to improve her circumstances which also affects the opportunities of her children. Thus this barrier is entrenched across generations.

4-Patriarchy and the socio-cultural practices -

The patriarchal society of India assigns inferior status to the women. Gender disparity and inequality starts from the birth of a girl where even the birth of the girl child is restricted by the sex determination in the womb. Although female feticide is restricted through strict laws, the prevalent gap in sex ratio proves that people find ways to detect the fetus' sex. Thus the right to live is undermined and denied to a girl in a patriarchal Indian society. Preference for the male child is widely prevalent even in the educated class of Indian society. Preference for the male child is largely attributed to the access to heaven through male child by religious beliefs and the fact that the girl will only get married and will leave the house for her

husband's home. Other reasons are dowry, safety issues and succession rights. If the girl is born then also she is kept in several restrictions, where physical mobility is restricted and access to good education, health and financial resources is limited. The rights of a girl child throughout her life are only secondary to the rights of her brother. All of these hampers the healthy physical and mental growth of a girl.

At a young age, a girl is made to get married at an early age so that the responsibility is fulfilled earlier. This leads to early pregnancy and various pregnancy related problems. The health of the women is further deteriorated with no say in family planning. She is forced to produce several children until she gives birth to a son. Early pregnancy and several children with lesser gaps between two leads to further deterioration of her health. Due to the patriarchal cultural environment she hesitates to ask for and use contraceptives. Patriarchal social structure often leads to domestic violence and various types of harassment against women including rape, dowry burning etc. This inflicts not only physical abuse on the woman but also on her mental status. Widowhood further makes life harder for a woman since nobody takes charge for her well-being and health. Similarly, old age also proves detrimental to an elderly woman where she either remains entirely neglected or on the mercy of male breadwinner of the family. Arthritis, cataract, diabetes, breast cancer, cervical cancer are the commonly found diseases in elderly women. In this way, right from birth to old age, a woman's life and health remains at stake and taken for granted. In some way or other she remains dependent on the male in charge of the family due to absence of access to quality education, control over financial resources and mobility.

Similarly, socio-cultural practices of society are also pernicious to women's health. Early marriage of girls remains a concern for the government despite having strict laws. Early marriage poses a great threat for child brides and their children. It leads to higher risk for premature delivery, maternal mortality, child mortality and other health issues. Gender roles assign domestic roles for women while community roles for men. This division of labour on the basis of gender makes women solely responsible for domestic responsibilities, care giving function, preparation of meals, child rearing, and other domestic chores. Thus domestic unpaid and unacknowledged work neither provides financial independence nor equal status in the family. Amidst these responsibilities time for health care remains a remote thing.

Culture and traditions expect women to be care giving and sacrificing. This belief system is so embedded in the society that a woman is expected to eat after providing food to all other members of the family. Thus, a woman's turn in food allocation and distribution in the family comes only at last. This makes women hesitate in asking for extra meals and nutrition even during her pregnancy, making her deficient in nutrition. Similarly, the beliefs related to pregnancy and child care are responsible for the non-institutionalized delivery of women and treatment of illness by the quacks. In rural areas, the illness of women is associated with the effect of evil eyes and displeasure of the supernatural spirits. The local practices adopted by the women during menstruation such as use of ash lead to various types of infections among the girls. Hygiene practices followed during child birth at home also remain unhygienic and lead to health problems and infections in further life of the women. Postpartum mental health, and anxiety is

rarely been addressed. Thus, patriarchy and socio cultural practices are significantly responsible for the neglect of health of Indian women.

KEY GOVERNMENT PROGRAMMES AND POLICIES REGARDING WOMEN HEALTH:

The government has taken various efforts and made provisions to safeguard women and child health. Following are the key government programmes and policies related to women and child health -

1- **Janani Suraksha Yojana (JSY)** - The program was launched in 12th April 2005. The objective of the program was to reduce maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. This was basically a cash transfer program which provides incentives for institutional delivery particularly for lower income women. It has identified ASHA worker as a link between government and pregnant women. The program has successfully facilitated over 100 million institutional deliveries since its launch and thus has contributed significantly to reduce maternal mortality in India. (*Janani Suraksha Yojana :: National Health Mission, n.d.*)

2- **Pradhanmantri surakshit matrutva abhiyan (PMSMA)** - This program was launched on July 31, 2016. The objective of this program is to provide quality antenatal care to the pregnant women including one guaranteed checkup per month with a qualified doctor. Under this campaign a minimum package of antenatal care services are provided to pregnant women in their second and third trimesters, at government health facilities in both Urban and rural areas. (*Pradhan Mantri Surakshit Matritva Abhiyan :: National Health Mission, n.d.*)

3- **Pradhan Mantri Matru Vandana Yojana (PMMVY)-**

The program is a maternity benefit program which was started on 1st January 2017. The scheme is implemented by The Ministry of Women and Child development and is a part of Mission Shakti for Women Empowerment. The program provides partial wage compensation to pregnant women and nursing mothers to encourage proper nutrition and regular health checkups. (*Doc2025825619601.Pdf, n.d.*)

4- **LaQshya (Labour room quality improvement initiative)** - Identifying that half of the maternal death each year can be prevented by providing quality health care, the ministry of health and family welfare has launched a program LaQshya on 11th of December 2017, to provide quality improvement initiatives in labour rooms and maternity operation theatres. It aims to improve quality of care for mothers and newborn during intrapartum and immediate postpartum period in order to reduce maternal and newborn mortality. (*Labour Room Quality Improvement Initiative (LaQshya) :: National Health Mission, n.d.*)

5- **Janani Shishu Suraksha Karyakram (JSSK)** - This program was launched in June 2011 to eliminate out of pocket expenses for both pregnant women and sick infants. Under this program essential care is provided to the mother and her neonate within 48 hours. In 2014, the program was extended to all anti-natal and postnatal complications of pregnancy and similar and entitlements have been put in place for all sick newborns and infants up to 1 year of age assessing public health institutions for treatment. (*Janani-Shishu Suraksha Karyakram :: National Health Mission, n.d.*)

CONCLUSION

As World Health Organization defines “Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity”, health is a comprehensive term. Indian women face health disparities due to systemic societal challenges embedded in the patriarchal social setting. The social cultural practices of India assigns secondary position to a woman and so access to nutrition and good health services is a luxury for her. Women's health cannot be separated from her social and economic status. Although various government policies and programs are working towards a betterment of women's health in India, much is needed to be done and achieved. Meaningful changes can be brought about through education, better health care facilities, women empowerment and greater gender equality practices at home.

REFERENCES:

1. Doc2025825619601.pdf. (n.d.). Retrieved 17 April 2026, from <https://static.pib.gov.in/WriteReadData/specificdocs/documents/2025/aug/doc2025825619601.pdf>
2. Gender and health. (n.d.). Retrieved 18 April 2026, from <https://www.who.int/health-topics/gender>
3. India witnesses a steady downward trend in maternal and child mortality towards achievement of SDG 2030 targets. (n.d.). Retrieved 18 April 2026, from <https://www.pib.gov.in/www.pib.gov.in/Pressreleaseshare.aspx?PRID=2128024>
4. Infant Mortality Rate Definition and Guide: | UNICEF USA. (2024, January 29). <https://www.unicefusa.org/stories/infant-mortality-rate-definition-and-guide>
5. Janani Suraksha Yojana: National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=841&lid=309>
6. Janani-Shishu Suraksha Karyakram: National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=842&lid=308>
7. Kumari, P. (2025). Women, Marriage, and Fertility Trends in India: A Socio-Demographic Study. 12(9).
8. Labour Room Quality Improvement Initiative (LaQshya): National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1307&lid=690>
9. Maternal mortality. (n.d.). Retrieved 18 April 2026, from <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>
10. Nagla, M. (2025). Women and gender studies: A textbook. Rawat Publications.
11. Paavani, G., & Koti, J. (2019). ASPECTS OF GENDER DISPARITIES. 6(6).
12. Pradhan Mantri Surakshit Matritva Abhiyan: National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1308&lid=689>
13. Saggurti, N., & Gupta, H. (2025). From population goals to reproductive health autonomy: Reframing India's fertility transition. The Indian Journal of Medical Research, 162(1), 1. https://doi.org/10.25259/IJMR_1718_2025

14. Sokoya, T., Zhou, Y., Diaz, S., Law, T. D., Himawan, L., Lekey, F., Shi, L., Griffin, S. F., Gimbel, R. W., & Jing, X. (2025). Health Indicators as Measures of Individual Health Status, Their Perceived Importance, and Associated Factors: Cross-Sectional Observational Study.
15. JMIR Public Health and Surveillance, 11, e65616. <https://doi.org/10.2196/65616>
16. World Bank Open Data. (n.d.). World Bank Open Data. Retrieved 18 April 2026, from <https://data.worldbank.org>
17. Doc2025825619601.pdf. (n.d.). Retrieved 17 April 2026, from <https://static.pib.gov.in/WriteReadData/specificdocs/documents/2025/aug/doc2025825619601.pdf>
18. Gender and health. (n.d.). Retrieved 18 April 2026, from <https://www.who.int/health-topics/gender>
19. India witnesses a steady downward trend in maternal and child mortality towards achievement of SDG 2030 targets. (n.d.). Retrieved 18 April 2026, from <https://www.pib.gov.in/www.pib.gov.in/Pressreleaseshare.aspx?PRID=2128024>
20. Infant Mortality Rate Definition and Guide: | UNICEF USA. (2024, January 29). <https://www.unicefusa.org/stories/infant-mortality-rate-definition-and-guide>
21. Janani Suraksha Yojana: National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=841&lid=309>
22. Janani-Shishu Suraksha Karyakram: National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=842&lid=308>
23. Kumari, P. (2025). Women, Marriage, and Fertility Trends in India: A Socio-Demographic Study. 12(9).
24. Labour Room Quality Improvement Initiative (LaQshya): National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1307&lid=690>
25. Maternal mortality. (n.d.). Retrieved 18 April 2026, from <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>
26. Paavani, G., & Koti, J. (2019). ASPECTS OF GENDER DISPARITIES. 6(6).
27. Pradhan Mantri Surakshit Matritva Abhiyan: National Health Mission. (n.d.). Retrieved 17 April 2026, from <https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1308&lid=689>
28. Saggurti, N., & Gupta, H. (2025). From population goals to reproductive health autonomy: Reframing India's fertility transition. *The Indian Journal of Medical Research*, 162(1), 1. https://doi.org/10.25259/IJMR_1718_2025
29. Sokoya, T., Zhou, Y., Diaz, S., Law, T. D., Himawan, L., Lekey, F., Shi, L., Griffin, S. F., Gimbel, R. W., & Jing, X. (2025). Health Indicators as Measures of Individual Health Status, Their Perceived Importance, and Associated Factors: Cross-Sectional Observational Study. *JMIR Public Health and Surveillance*, 11, e65616. <https://doi.org/10.2196/65616>
30. World Bank Open Data. (n.d.). World Bank Open Data. Retrieved 18 April 2026, from <https://data.worldbank.org>