

# Namaste India

## *Indian women and health*



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**In these enlightened and networked times, Indian women from established migrant communities and first generation immigrants from India, are all part of our wider global community. They have courage, strength and a voice, and it behoves us to attempt to understand their needs as doctors as well as we can.**

India is the world's largest melting pot of cultures that have co-existed from ancient pre-history to date. It has been justly described as a land where civilisations from many different centuries co-exist together, in the here and now. Sometimes these differing civilisations exist in cultural synergy and with some degree of harmony. Other times, there is co-existent disharmony. This paradoxical, timescale defeating and contradictory aspect of

Indian life remains unchanged this past 300 years. That makes the Indian subcontinent more than chaotic to comprehend for more orderly and smaller cultures.

In any culture, women have to be understood both from within their own ethnic traditions and without their ethnic cloaks to obtain a truly holistic view of their status and health in that society. Even a small understanding of Indian women, therefore, does demand understanding some of the chaotic richness of their culture.

### **Genetics, migration, culture, demographics and influence on women's health**

Ancient Indians descended from the genetic mixing of three distinct indigenous settled groups. These people came from the Indus Valley civilisation of Mohenjo Daro and Harappa (modern day Sind in Pakistan); the Dravidians from South India; and the invading nomadic Aryans from the Caucasian mountains (modern day Azerbaijan, Armenia, Georgia, Southern Russia and Turkey).

Migration all over the subcontinent and mixing of all these groups occurred throughout pre-history, from 5000 BC to about 2000 BC (known as India's Vedic times) until their genes became indistinguishable from one another and their cultures intertwined to a large degree. These people were all sophisticated in their cultural traditions and ancient lineage.

*Ayurveda* (Indian Vedic knowledge of health sciences) has been passed down from these Vedic pre-historic people to the current day. Many of *Ayurveda's* scriptures and writings document public and women's health, in particular, about 2000 years before Christ.

### **Ancient india, the last millenium and colonial india**

There is historical evidence in literature and in ancient temple carvings, both written and oral, that Indian women had education, reasonable nutrition, rights as daughters, mothers and wives, prominence as social advisors, and stature as goddesses. Clearly, some lived to very old age despite the hardships, infections and privations of any pre-historic or ancient civilisation.

In ancient India, it is possible that women's elevation to the status of 'goddess of power, nature, health and richness' came from the need to nurture women and care well for their health. Of all the world's religious traditions, India has a special place in this regard. To this day, the Indian goddess, is worshipped in her varied manifestations on par with, and sometimes with greater devotion and status than, 'male gods' and their manifestations.

In ancient India, women and girls were therefore known to be healthy and strong enough to ride, shoot, hunt and if needed, go to war. Indian women were recorded in pre-history as educated to read, write, perform rituals, play on instruments and sing.

Women had special celebrations dedicated to womanhood. Various stages such as puberty, pregnancy, delivery and menopause are all celebrated even today at various ritual Hindu ceremonies.

Many women in ancient India ruled large kingdoms. Some old women walked many a hazardous pilgrimage of great hardship in their menopause. Many older women voluntarily gave up family life and wandered as singing devotional bards from kingdom to kingdom.

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In this ancient land, therefore, it appears that women's health must have been pretty good despite the human costs of pregnancy, delivery and reproductive exertions. Women were mostly able to reach and pass the menopause, even if that stage occurred a decade earlier than it does today.

During the time of the Mughal Empire (circa 1300-1700s AD) and in Colonial times (1700- 1947), the status of Indian women dwindled somewhat. There were waves of cultural and religious influences sweeping through the subcontinent from other parts of the world such as Persia and Europe. These occurred through several successive and repeated wars. The invasions of India greatly affected Indian women.

Women became more like silenced possessions rather than independent thinking beings as they were previously regarded. Women's nutrition suffered badly. Girls were seen as a hardship to feed and support compared to boys, and they were married off as fast as possible to avoid further expenses for their care. Many girls were lost in childhood or with early age breeding (as early as 10 to 13 years of age) and many had traumatic early adolescent childbirths.

British Colonial India (1700s to 1947 AD) tried, with some success, to educate Indian girls and maintain female health. The colonial conquerors forbade by law, Indian child marriages, widow burnings and female infanticide. They had moderate success.

However, it was the call for independence from the Raj by Mohandas Karamchand Gandhi and his wife Kasturba Gandhi (and his Indian Congress compatriots) that did much for Indian female emancipation. With these changes came better reproductive health and general health for Indian women.

At this point, began the true journey to improve women's reproductive health in modern day India. Gandhi called for a nationwide ban on child marriage. He encouraged widow remarriage and female literacy. Gandhi and his wife and many other regional leaders actively promoted the healthy woman as the hidden wealth of Indian society.

This support led to the resurgence of female education and health protection for girls. Active feminine participation in the long fight for Indian independence led to an improvement in women's health in general.

## Cultural influences in modern day India

India is a caste and class-ridden society. Each caste has now got its own economic class system as well, further complicating matters.

Socio-economically upper class and middle class India has learnt, through decades of education and social development, to emulate those ancient, inspiring and emancipated times.

Daughters of well-heeled upper class families fare better health-wise in India today in comparison to their economically disadvantaged sisters. India has exported many such educated daughters in these past few decades. They carry some of their genetic and cultural gifts to many parts of the world, as also their genetic and health baggage, to the countries that they migrate to.

Women from families with adequate finances are generally educated, well looked after, immunised, nourished and nurtured.

## Menstruation and contraception

Puberty is a time for some social awkwardness but it is religiously celebrated as a 'coming of age' in many clans. Girls will rarely go on the pill at this time for period pain or irregularity related issues. Going on the pill before 'marriage, a common Indian pseudonym for before sex', is still suggestive to most overprotective families as a license to promiscuity. Therefore, the combined oral contraceptive (COC) is not considered lightly as a treatment option for young girls, however beneficial gynaecologists might think it is.

Menstruating girls are usually very sheltered in urban India. Though socialising may be encouraged amongst girls, youth mixed-sex groups will be very circumspect, at least in public, once girls start to menstruate. In medieval times, menstruation was seen as an 'unclean time'. Brahmanic cultures, which encouraged 'keeping things as clean as possible', often misconstrued traditions and isolated menstruating women to dark and remote parts of the household until she had her purifying bath after cessation of menses. Fortunately, this practice is now redundant in most of modern India.

Interventional management and vaginal/vulval examinations are also rare for dysmenorrhoea or menorrhagia at this young adolescent age, as most girls are considered unsuitable to be gynaecologically examined, presuming their virginity. Though the

physiology of puberty might be discussed openly now, sexuality itself is not openly discussed with post-pubertal adolescents.

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In socio-economically deprived India, pubertal girls may often have to work daily to augment a family's meagre income. Some get education to the age of about 15 and others a bit longer than that. In exceptional families, ambitious for their girls to have a better life, some will go to universities. Most of these girls will get married by the age of 18 to 20 and their adolescence before that is all about pure survival. There is just enough for a living, therefore periods may be scant, nutrition inadequate and bone health and growth stunted. Many are seen at termination clinics in the public sector to terminate unplanned pregnancies resulting from unprotected and early sexual exposure. Some will visit free family planning clinics for fittings with a Multiload in secret. The IUCD is a popular choice in these settings for contraception, as it is seen as safe and private. Many times, such young women will attend Family Planning Association (FPA) clinics without mothers or men to plan their fertility and sexual activity in secret.

## Sexuality

Adolescent sexuality is the hidden Indian urban problem and goes hand in hand with burgeoning though completely preventable unplanned pregnancy rates, termination rates and sexual infective disease rates. Only as recently as 2006 did condoms for safe sex start appearing in the television media. Pre-marital sex is common in both high and low socio-economic groups of adolescents, rich or poor, but it is very hidden and secretive. Indeed, to acknowledge publicly that premarital sex even exists is taboo. This creates a huge problem for effective sexual education.

Sexuality brims over in innuendo everywhere in modern day India and throughout its religious and artistic traditions, but it is never openly exposed or dissected. Modern day India does, however, discuss and dissect it in live TV shows hosted by feminist/libertarian show presenters.

Lower socio-economic classes in India also suffer huge problems with gender-based domestic violence against women and young girls, human trafficking and child prostitution. Each has consequent and severe sexual and gynaecological health issues for young women and the children who come forth from them.

## Marriage

India is the land of the arranged marriage. Despite India's ancient and supposed historic openness with sexuality (the *Kama sutra*, the book on love making techniques, 756 BC), the majority of marriages in traditional families are arranged. In the past two decades, however, this has been dented by a large rise in self-willed marriages, affectionately and commonly known in 'Indian English' as 'love marriages'.

The age at which urban educated women marry has risen sharply, but rural India still sees a large proportion of teenage marital unions before girls are mature physically or emotionally.

### Childbirth and postpartum care

A married woman's first pregnancy is celebrated in most Hindu cultures, as Hinduism celebrates fulfilled fertility in womanhood. None of the Hindu goddesses, except for one (Kanyakumari or virgin goddess), is a virgin. The mythological story of each goddess reveals love, lovers, sexuality, children and marital enjoyment.

Caesarean section rates are high in urban centres. Convenience for the parents, the family and the obstetrician play a large part in this statistic. Sometimes, caesareans are done because parents wish to 'time' the baby's birth exactly right so he/she will get a good birth horoscope. Astrology is a revered part of mainstream Indian culture. Sometimes caesareans are done because they are fashionable and lucrative. That said, the indications are clinically the same as for Australia and New Zealand. However, caesar rates are on the rise. Neonatal care in good private hospitals is generally average to good.

Rural India and low economic groups, however, tell a very different story regarding maternal and child healthcare.

Poorer women will often have NO antenatal care. Eclampsia rates are exceedingly high, convulsion numbers also very high. India is living proof that lack of antenatal care corresponds directly with a huge rise in pre-eclampsia, eclampsia and related feto-maternal sequelae.

Hepatitis in pregnancy, usually fatal, is known and occurs more often than it should in these settings. HIV is rife and transmitted actively due to poor prevention policies and practices.

The poor women of India will either survive a pregnancy very anaemic and undernourished with low birth weight babies, or they will have dire prenatal complications. Neonatal care can be appalling or absent for such women.

India still has one of the world's highest maternal and neonatal mortality rates in the world. Women die in childbirth in India from simple treatable complications, infections or preventable childbirth issues every minute of every day in massive numbers, as do newborns. Most of this mortality occurs in socio-economically underprivileged India.

The economically disadvantaged, poor and rural folk in India continue to have one of the highest maternal, perinatal and child mortality rates in the world. Women and girls from poorer backgrounds fare the worst and have the highest rates of death in these reproductive periods of their lives.

Lactation is seen as a normal life event in India. Most women breastfeed a few months, though in privacy or at least shielded by their *sarees*. Breastfeeding in public, fully exposing a breast or nipple, would cause arrest for indecent exposure in India.

The poor will often breastfeed for a year or more. More fashionable women or working women will switch to bottles earlier. Powdered milk is available though expensive. Sanitation around bottle feeding is a public health issue in India, with many babies dying of E Coli/ bacteroides gastroenteritis as a result of hand washing hygiene issues.

### Menopause

Most Indian women used to and still do see the advent of their menopause as special and liberating. They no longer need contraception, they are not bothered cyclically with menses, and their androgens make their self-esteem and energy blossom. Many

a docile Indian bride becomes a dragon after her menopause. Matriarchs rule the house in such communities and they are almost always healthy, obstreperous, difficult, menopausal women! Such women do not acknowledge any problems as a result of the menopause and see it as a blessing to their health. The menopause is also seen in traditional Hinduism as the 'age of feminine wisdom' or the 'true coming of age'. Older menopausal women are always revered in a culture that sanctifies age and wisdom in everyday spiritual life. Menopausal women often begin to dictate their lack of sexual availability to their husbands as they never would have previously.

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Hinduism does see abstinence after menopause for women and abstinence after a certain age (somewhere around 55 to 60 years) for men as a right of passage and a good option in life. This helps with attitudes towards menopause.

Since Western influences have swept through the nation this past 30 years, some urban, educated and well-off Indian women see menopause as a similarly decaying process to be feared, as many women in the West do. However, the use of hormone replacement therapy is restricted to the upper and richer echelons of Indian society.

### Attitudes to gynaecological surgery

The urban, educated, liberated and monetarily well-off woman in India feels similarly towards gynaecological surgery as any other woman in the world might: access the best professionals, pay for the best affordable service, avoid risks if at all possible and avoid unnecessary surgery. All of these precautions are shared globally.

However, if a woman is from a traditional family, there may be much control over her decision to have surgery, either from the family matriarch or her husband. In some cases, even the children will tell her what to do. I have had many phone calls from Indian husbands irate that I will not share the details of the consultations I had with their wives with them. They simply do not understand the concept of her individual right to privacy or choice.

Traditional Hindu women are often very shy and will resent having to see male gynaecologists. They are reluctant to be examined in the first place and even more reluctant to be examined in the nether regions by a strange man. Modesty is a key issue.

Hindu women, brought up traditionally, will almost never allow even other women to see them naked. They prefer to keep their bodies covered in public and see this as careful and good behaviour. Having a considerate and kind nurse chaperone them during gynaecological examinations, allows for genital modesty and is paramount to making these women feel safe.

Indian women also find intrusive vaginal or gynaecological examinations difficult (as most women do). They are not at all at ease with the exposure required to complete the examination. Many will shriek and squirm and snap shut their legs or pull at your instruments, making the examination a difficult and awkward process. A 1996 *BMJ* article published a study in the UK, which described South Asian (Indian, Pakistani and Bangladeshi) women as the noisiest and most reluctant at gynaecological examinations. I always explain the value of examinations to women and allow

them to spend a few minutes with my nurse who is excellent at setting them at ease. Needless to say, cervical smear follow-up with such women needs to be encouraging, supportive and firm, otherwise you'll never get them to attend a regular screening program. They will conduct a program of their own to avoid having smears if allowed to.

However, attitudes to hysterectomy, if necessary, are progressive and pragmatic in all of India. If one needs the operation, one has it without further ado.

Many women, from all walks of life, participate voluntarily in tubal ligation programs. They are worried about producing too many children and know that their men will do nothing about it. I have known many a rural woman to walk three miles to a free tubal ligation camp, have the procedure laparoscopically under local anaesthesia without sedation, walk back with her toddler on her hips to her village, with her husband and mother-in-law none the wiser for it.

Vasectomy, on the other hand, has a very poor uptake in urban India. Though strong public female figures exist all over India, urban men share a rather macho culture, which avoids such measures as vasectomy and encourages widespread rumours about impotence after this surgery. India is the world's largest consumer of Viagra!

## Indian women's health and free public healthcare

The public system in India remains very poorly funded, abjectly starved of supplies and swamped with dire staff needs and shortages. Public hospitals in India are nightmarish places of poverty, disease and preventable tragedies.

Indian families save for healthcare and for a rainy day from the first day of paid employment or marriage or both. India does not have any social security – no earnings, no work, no food. Only the larger family will step in to help, not the Government. There is no public safety net of any nature.

Many families look after their own health, accessing reasonable and efficient private sectors for female healthcare.

Very little funding, if any, reaches the grass roots for public health screening and promotion of women's health.

There is no national cervical screening program in India, nor any move towards it, despite many educated protests to the Government.

Wealthier women, or those who can afford it, have random Pap smears with gynaecologists. There is no regulatory program nor a database. No pathology standardisation exists. There is no free three-year program for rural women, many of whom have never even heard of HPV or cervical smears. Cervical cancer rates in India are consequently on the rise and one can see some dreadfully advanced cases. The fact that this terrible disease is directly related to sexual activity and HPV transmission in more than 90 per cent of cases and is relatively preventable, is not publicly acknowledged.

## Gender imbalance

No article on Indian women's health can be complete without some mention of India's contribution to gender imbalance and the horrible act of sex-selective reproductive health practices.

Unfortunately, even economically middle and upper class India has fallen prey to the pressure to produce boys rather than girls and

the cultural temptation to view a girl as a burden rather than a gift. Prenatal ultrasound sexing is rife in many dubious clinics. It is openly advertised despite the law prohibiting it.

Sex-selected termination of pregnancy and the abortion of female fetuses are very common despite being against the law on paper. Rising numbers of boys and falling numbers of girls in India over the past two decades, since ultrasound fetal sexing became prevalent, has caused much concern to public health agencies worldwide. Many girls are therefore never born, though conceived, and this misogynistic abuse carries on in the name of medical practice in India.

## Diabetes

Indians anywhere in the world have to take the menace of type 2 diabetes very seriously. We must all understand the problems and risks of insulin resistance, polycystic ovary syndrome (PCOS), the phenotype of insulin resistance, and obesity and its associated risks in Indian women.

All Indians from the subcontinent are heavily predisposed to the disease in their genetic make-up and this is exacerbated by factors such as modern diets, body shape, abdominal fat and attitudes to exercise. I screen all Indian girls, adolescents and women carefully for predisposing factors and/or the condition itself when the opportunity presents itself. I would advocate you do so as well.

## Conclusion

This was an enormous topic to cover with any semblance of adequacy in one article. However, I chose certain interesting and relevant points, from ancient history to modern times, to explore in depth. My article is by no means complete in any way and I mean to offend no one, I am expressing an opinion.

There is a very large number of Indians in the world now, which makes accepting, understanding and working with them less of an option and more of a reality in this century.

Urban India is undergoing economic development in some parts and large sectors of the population are obscenely rich beyond any average person's wildest imaginings. Urban and 'well to do' India has health facilities, though access to them is expensive and self-funded. Women from this sector of Indian society fare reasonably well in terms of their reproductive and gynaecological health.

Sadly, a huge section of the world's abjectly poor people also live in India under conditions of unimaginably raw, inhumane poverty. While the current governments of India obsessively talk up the mantra 'India is an economic force to reckon with', millions of little Indian girls continue to suffer abject poverty, every kind of abuse and social neglect, serious malnutrition, communicable and infective fatal diseases, and HIV and STDs from birth.

Indian women in our communities are deserving of our effort to understand them from the perspective of whichever race, creed, culture, religion, country and background they come from, like other women. The background I have just provided, though not extensive, is hopefully a small, modern summary that will enhance understanding about the Indian woman, her psyche and cultural background, and her genetic lineage.

## References

I have used international journal publications, public health literature, WHO, UN and UNICEF literature, Medecins sans Frontier publications, books and references on history, archeology and civilisation and publications on modern Indian culture to write this article.