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Beyond healthcare: Rethinking women's health in Uttarakhand

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1. Introduction

Over the past two decades, Uttarakhand has made notable progress in improving the health of women and children. Institutional deliveries have increased; antenatal care has become more widely available and maternal health indicators have improved steadily (IIPS, 2026). These achievements reflect sustained investments in public health and deserve recognition. Yet it is only part of the story. Behind these encouraging trends are persistent differences in how women experience health and healthcare across the state. It has been documented that in hilly districts, access to healthcare for most of the women continues to be shaped as much by geography, livelihoods and social circumstances, as by the availability of medical services (Janeja, 2017).

This contrast is particularly relevant in Uttarakhand because the state's geography influences almost every aspect of daily life. A health facility may exist within a reasonable distance on paper, but reaching it can involve long journeys, unreliable transport and considerable expense. During the monsoon, road closures and landslides may interrupt access altogether. These challenges are not unique to emergency care; they affect routine antenatal visits, follow-up consultations, treatment for chronic illnesses and preventive health services. Consequently, improvements in healthcare infrastructure do not always translate into equitable access for those who need it most.

Women experience these constraints in distinctive ways. In many rural communities, their responsibilities extend well beyond household work. They contribute substantially to agriculture, livestock management, childcare and the care of older family members. Male outmigration has further increased these responsibilities, leaving many women to manage households and farms simultaneously (Dutta and Mishra, 2021). Seeking healthcare is therefore rarely an isolated decision. It must often be balanced against domestic responsibilities, financial limitations and the practical difficulties of travelling to health facilities. These realities receive far less attention than service coverage indicators, yet they influence health throughout a woman's life.

Public health has long recognised that health is

shaped not only by medical care but also by the conditions in which people live and work. Education, nutrition, transport, livelihoods and women's autonomy are not peripheral concerns; they determine whether healthcare can be accessed, accepted and sustained. Focusing exclusively on healthcare services therefore provides only a partial understanding of why health inequities persist despite measurable improvements in service delivery (Bisht and Bhushan, 2023).

This editorial argues that the next phase of progress in women's health will depend less on expanding healthcare services and more on addressing the structural conditions that influence health across the life course. This perspective does not diminish the importance of healthcare, rather it recognises that equitable health outcomes require policies that extend beyond the health sector and respond to the realities of mountain communities.

Beyond Healthcare

The improvements seen in women's health over the past two decades are real, but they also expose an uncomfortable reality. Better health services have not eliminated inequities because many of the factors influencing women's health lie beyond the reach of the healthcare system. In Uttarakhand, access to care is shaped as much by where a woman lives, the work she does and the choices available to her as by the presence of a nearby health facility. Expanding services remains necessary, but it is unlikely to be sufficient on its own.

In hilly states like Uttarakhand, mountains influence how people live, travel and use health services. A journey that appears short, may require several hours of travel, multiple modes of transport or, during periods of heavy rain, may not be possible at all. For women who are pregnant, living with chronic illness or caring for young children, these practical constraints often determine whether healthcare is sought early, delayed or forgone altogether. Geography, therefore, is not merely a backdrop against which health services operate; it shapes the way healthcare is experienced.

Yet geography alone does not explain the persistence of health inequities. Social and economic circumstances frequently determine whether available services can actually be used. The National Family Health Survey (NFHS-5) shows encouraging improvements in institutional deliveries and maternal healthcare utilisation across Uttarakhand (IIPS and ICF, 2021). At the same time, the survey also reminds us that anaemia remains a major public health concern among women of reproductive age and that decision-making regarding personal healthcare is still not universal. Anaemia continues to affect more than two out of every five women in Uttarakhand (IIPS and ICF, 2021). Although iron supplementation is an important intervention, persistent anaemia cannot be viewed solely as a clinical problem. It reflects the cumulative effects of diet, poverty, education, repeated pregnancies and gender-based inequalities in access to food and healthcare. Treating anaemia therefore requires more than distributing iron tablets; it requires addressing the circumstances that allow nutritional disadvantage to persist across generations. These findings point to a broader issue: improved service coverage does not necessarily translate into improved health when underlying social determinants remain unchanged.

Nutrition provides a useful example

Education has a similarly wide influence on health. Women with better educational opportunities are more likely to access preventive services, recognise health problems early and make informed decisions about their own care. Education also influences employment, financial independence and confidence in interacting with health systems. However, education alone is not enough if women continue to have limited autonomy in decisions affecting their health. In many households, decisions about seeking care remain closely linked to family responsibilities, financial constraints and social expectations. Healthcare utilisation, therefore, cannot be understood independently of the context in which women live.

Economic realities further reinforce these challenges. Agriculture remains the principal source of livelihood in many rural areas, but incomes are often seasonal and uncertain. The cost of healthcare extends well beyond consultation fees. Travelling to a health facility may involve transport expenses, lost wages and time away from household

responsibilities. For women, these indirect costs can be as significant as the illness itself. Publicly funded health insurance reduces some financial barriers, but it cannot overcome the challenges posed by distance, inadequate transport or the opportunity cost of leaving work and family obligations behind.

Taken together, these observations suggest that women's health in Uttarakhand is shaped by a combination of interacting influences rather than by healthcare alone. Medical services remain indispensable, but they operate within a wider social environment that determines who is able to benefit from them. Recognising this distinction shifts the conversation from improving healthcare to improving the conditions that make good health possible. It is this broader perspective that is likely to define the next phase of progress in women's health, not only in Uttarakhand but in other mountain regions facing similar challenges.

The Unfinished Agenda

Much of the progress in women's health over the past two decades has been measured through improvements in maternal and child health. This emphasis has been both necessary and successful. Expanding institutional deliveries, improving antenatal care and reducing maternal mortality have transformed reproductive health in India. Yet success in one area can sometimes narrow our perspective. Women's health is still too often viewed through the lens of pregnancy, whereas the realities of women's lives extend far beyond their reproductive years.

This is particularly evident in villages, where daily life involves a combination of agricultural work, household responsibilities, caregiving and, increasingly, the management of farms in the absence of male family members who have migrated for employment (Directorate of Economics and Statistics, 2022). These responsibilities are physically demanding and leave little opportunity to prioritise personal health. Minor health problems are often ignored until they interfere with daily functioning, while preventive care frequently receives less attention than immediate family needs. Such patterns are rarely reflected in routine health indicators, yet they influence health throughout adulthood.

Another area that deserves greater attention is women's health beyond the reproductive years. India is experiencing a steady rise in non-communicable diseases, and women are living longer than previous generations. Hypertension, diabetes, cardiovascular disease, osteoporosis and cancers increasingly contribute to illness among middle-aged and older women. These conditions require continuity of care rather than episodic treatment. Health systems designed primarily around maternal and child health are not always well equipped to meet these changing needs. As the demographic profile changes, so too must the ways women's health be understood.

Mental health also remains relatively invisible within discussions on women's health. While evidence from Uttarakhand is limited, studies from similar settings suggest that social isolation, financial insecurity, caregiving responsibilities and limited autonomy can influence psychological wellbeing. These concerns are easily overlooked because they seldom present as medical emergencies, yet they affect quality of life, productivity and family wellbeing. Integrating mental health into primary healthcare would therefore represent an important step towards more comprehensive care.

These observations point towards the need for a life-course perspective. Women's health should not begin with pregnancy or end after childbirth. It is shaped by experiences that accumulate from adolescence through older age, influenced by education, nutrition, employment, family responsibilities and opportunities to access healthcare at different stages of life. This perspective broadens the focus from preventing maternal deaths to promoting lifelong health and wellbeing. It also reminds us that improving women's health requires continuity rather than a series of disconnected programmes.

Recognising this broader agenda does not diminish the achievements made in maternal health. Instead, it builds upon them. The next phase of progress will depend on whether health systems are able to respond to the changing needs of women as they move through different stages of life, while acknowledging the social and economic realities that continue to shape their health.

Looking Ahead

Uttarakhand has reached an important point in its public health journey. The challenge today is no longer limited to expanding healthcare services; it is to ensure that these services respond to the realities of the communities they are intended to serve. The gains made in maternal and child health provide a strong foundation, but they should also encourage a broader conversation about health equity and the changing health needs of women.

One implication is the need to move beyond programme-based approaches towards a more integrated model of care. Women's health cannot be compartmentalised into separate initiatives for nutrition, maternal health, non-communicable diseases or mental health when these issues are closely interconnected in everyday life. Primary healthcare provides the most appropriate platform for such integration, particularly in mountain regions where continuity of care and long-term relationships between health providers and communities are often more valuable than episodic specialist care. The ongoing strengthening of Health and Wellness Centres under the Ayushman Bharat programme offers an opportunity to move in this direction (Ministry of Health and Family Welfare, 2022).

A second consideration is the importance of context. Health policies are often designed around national priorities, yet their implementation inevitably depends on local realities. Strategies that work well in urban or easily accessible areas may require adaptation in mountain districts where geography influences transport, livelihoods and service delivery. Recognising these differences is not a case for creating parallel health systems, but for allowing sufficient flexibility so that local health services can respond to local needs.

There is also a need to broaden the evidence base that informs policy. Much of the available literature on women's health in Uttarakhand continues to focus on maternal and child health, reflecting priorities that have rightly dominated public health over the past two decades. Comparatively less attention has been given to occupational health, healthy ageing, mental wellbeing and the long-term consequences of physically demanding work in mountain communities. These are not peripheral issues. As life expectancy increases and the burden of chronic disease grows, they will become increasingly important in determining women's health and quality of life. Future research should therefore move beyond documenting disparities to evaluating interventions that are practical, acceptable and sustainable in geographically challenging settings.

Finally, the experience of Uttarakhand reminds us that communities are not passive recipients of healthcare. Frontline health workers, self-help groups and local institutions have contributed substantially to improving health awareness and strengthening links between communities and the formal health system. Their greatest contribution, however, lies in something less tangible - the understanding of local realities that no policy document can fully capture. Health systems become stronger when that knowledge informs planning rather than being treated as an afterthought.

The future of women's health in Uttarakhand will therefore depend not only on better healthcare, but on a broader understanding of what creates health. Medical care will remain central, but it cannot work in isolation. Progress is more likely when health services are supported by investments in education, nutrition, transport, livelihoods and gender equity, and when policies are shaped by the experiences of the women they are intended to serve. That perspective may ultimately prove to be the most important lesson that mountain regions can offer to public health.

Conclusion

The progress made in women's health in Uttarakhand over recent decades is substantial and should be acknowledged. At the same time, persistent inequities remind us that improvements in healthcare do not automatically translate into improvements in health. Geography, education, livelihoods, nutrition and women's autonomy continue to influence opportunities for health in ways that routine indicators often fail to capture.

The experience of Uttarakhand suggests that the next phase of progress will depend less on expanding healthcare services than on making

health systems more responsive to the realities of women's lives. A broader understanding of health-one that recognises the contribution of social conditions alongside medical care-offers a more meaningful path towards equity. In that sense, the lessons from the Himalayan region extend well beyond its borders. They remind us that the measure of a health system lies not only in the services it provides, but also in its ability to reach people where they are and respond to the circumstances in which they live.

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