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MAJHDHAAR DIALOGUES

Reframing Women's Wellbeing Beyond Maternity

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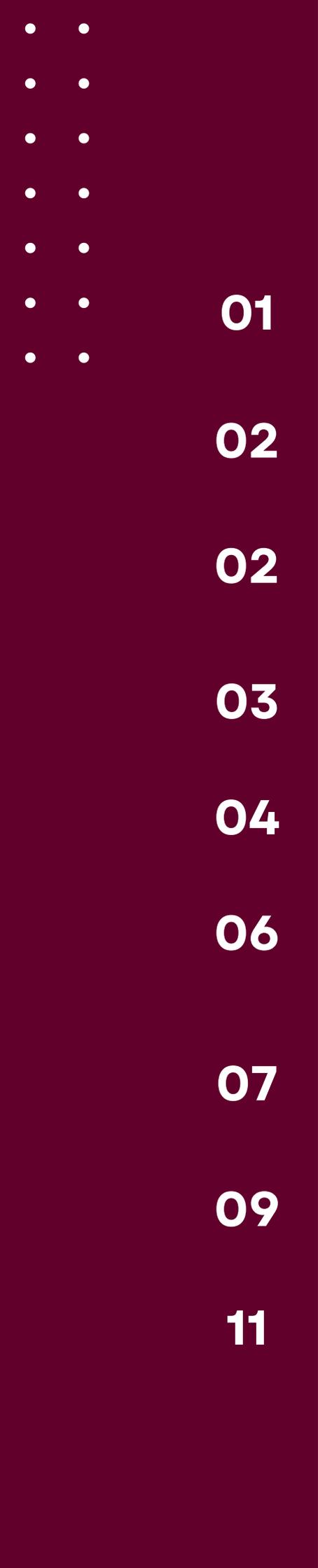


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Executive Summary

Women's health in India continues to be organised primarily around maternity and reproduction. While this focus has improved maternal outcomes, it has also narrowed how women's wellbeing is recognised and addressed. Most women spend much of their lives neither pregnant nor acutely ill, yet living with persistent pain, fatigue, mental distress, and chronic conditions that are frequently normalised and overlooked.

The Majhdhaar Dialogues, held at ICMR-RMRC Gorakhpur, brought together public health administrators, clinicians, researchers, programme implementers, and community voices to examine women's wellbeing beyond maternity. The dialogue foregrounded lived experiences, highlighted gaps in health systems and programme design, and explored pathways for research, intervention, and collaboration grounded in women's everyday realities.

Discussions underscored how women beyond pregnancy remain largely invisible within health programmes that prioritise fertility and child outcomes. Conditions such as anaemia, depression, menopause-related changes, osteoporosis, thyroid disorders, diabetes, and cervical cancer remain under-recognised and poorly addressed. District experiences from Gorakhpur demonstrated both the feasibility of expanded screening and the constraints posed by workforce, documentation, and follow-up.

At the centre of the dialogue were narratives of women in the Majhdhaar—those balancing work, caregiving, and social expectations while accumulating untreated illness. These accounts revealed patterned journeys of delayed care, loss of trust, and repeated expenditure without resolution, reflecting systemic rather than individual failures. A key emphasis was the need to lower thresholds for care-seeking, including rest, nutrition, and community support.

The dialogue concluded with agreement on moving towards action through piloted, protocolised interventions; strengthened frontline capacity; routine and opportunistic screening; improved life-course data; and sustained community engagement. An MoU signed between ICMR-RMRC Gorakhpur and PCI India formalised collaboration to advance research and action on women's wellbeing beyond maternity.

Welcome and Opening Remarks



Dr Hari Shankar Joshi, Director, ICMR-RMRC Gorakhpur, opened the dialogue by noting that while many programmes exist for maternal health for women, there is a clear need to expand support beyond maternity. He emphasised that administrative backing is essential to ensure sustained work in this space.

He highlighted RMRC's institutional strengths and partnerships, noting that the Gorakhpur unit operates within the premises of BRD Medical College, and that complete teams are based at RML Medical College in Lucknow. He stated that RMRC is fully equipped to support expanded work on women's wellbeing.

Dr Joshi noted that ICMR currently supports 39 Model Rural Health Research Units (MRHRUs) across the country, which could be leveraged for Majhdhaar-related work. He outlined ongoing studies at RMRC on antimicrobial resistance and mental health, and shared plans for a nutrition study in collaboration with the ICMR-National Institute of Nutrition (NIN), Hyderabad.

He stressed that identification of problems alone is insufficient, and that interventions are necessary, aligning this approach with ICMR's broader goals. He also underscored the need to include mental health as a key component of women's health.

Women's Wellbeing Beyond Maternity for Viksit Bharat 2047

Dr A.K. Garg, Joint Director, Health, Gorakhpur Division observed that most programmes for women focus on fertility and anaemia, while women aged 35 years and above remain largely absent from public imagination and programme design.

He explained that most programme target groups are defined as women aged 15-45, resulting in women aged 35+ being hidden within community health systems and unable to access care. He emphasised the need to prioritise conditions such as depression, osteoporosis, cervical cancer, diabetes, thyroid disorders, and calcium and vitamin D deficiency.

Dr Garg also noted that people below the age of 35 rarely think about these conditions, leading to missed opportunities for prevention and early care.



Ground Realities and District-Level Innovations



Dr Rajesh Jha, Chief Medical Officer, Gorakhpur echoed that most programmes, cards, and campaigns have historically focused on children and pregnant women. He described the district’s Pink Card initiative, which initially focused on cancer screening and later expanded to include non-communicable diseases such as anaemia, with the aim of making screening “less scary and more palatable to people.”

He shared that over two lakh cards were issued. With support from AIIMS, 2,000 people were screened, revealing that 39% of women were anaemic, 17% hypertensive, and 19% diabetic. Among 440 women who underwent VIA screening, around 15 were identified as prospective cervical cancer cases. He acknowledged that documentation was limited due to programmatic workload.

Dr Jha stated that the district is now committed to completing screening for the entire 30+ population of Gorakhpur within the current and next financial year, and to using these learnings for planning. He noted that there is scope for collaboration if Majhdhaar is implemented locally.

He also described the second phase of the initiative, Pink Card Junior, focused on adolescents through sanitary pad distribution and blood tests. As the work progressed, he observed the need to address mental health, menopause-related changes, challenges faced by homemakers and families, and emerging concerns such as obesity. He stressed that identifying problems alone is not enough, and that comprehensive, scalable, and sustainable programmes are required.

Always Ill, But Not Ill “Enough”: Women in the Majhdhaar

This session formed the narrative core of the dialogue, bringing together lived experiences, practitioner reflections, and system-level insights to examine what women’s illness journeys look like in rural India, and why women remain “always ill, but not ill enough” to receive timely and appropriate care. The presentation opened with the voices of women in the Majhdhaar- working women at the centre of work, family and society:

Smt. Manjulata, an Anganwadi worker from Gorakhpur, described months of persistent drowsiness that she normalised as inevitable after hard work. Falling asleep in a shared auto became a joke. Only after falling asleep while making chapatis and burning her hand did she seek care. A delayed thyroid diagnosis led to long-term complications, weight gain, and doctors now advising knee replacement surgery.



Dr Rajshree Das, Senior Director, Health and Nutrition, PCI India reflected on similar delays among relatively empowered women. Calling herself an “educated illiterate,” she described postponing care due to professional pressures and caregiving responsibilities. She described experiencing menopause in her early 40s. It took her almost a year to consult a gynaecologist because she had heard that menopause usually happens between “45–50 years.” When she did consult, she was told to “enjoy my freedom.” However, she continued to have periods every three to four months even after menopause, and over time, “sanitary napkins became my bestie.”

She kept trying to identify triggers for the irregular bleeding and eventually recognised stress as a major factor. At the same time, she noted that stress was inevitable given her professional responsibilities and the demands of caring for children at a crucial stage in their lives.

In September 2025, she experienced prolonged bleeding that “went on forever,” at which point she realised she could no longer avoid seeking care. In November 2025, she underwent a hysterectomy. Reflecting on this experience, she observed that many women share similar trajectories, repeatedly deprioritising their own health.

She emphasised the need to increase awareness, take timely action, and ensure appropriate family-level support for women. She also highlighted that there are likely many women like her in urban India—educated, working, and relatively empowered—who prioritise career, family, and home while consistently deprioritising their own health. She underscored that women in the Majhdhaar include both women like herself and women like Manjulata, and that both require support and intervention.

These narratives urged others in the room to share anecdotes of neglect, delay and women's fate in the Majhdhaar as well. **Dr Rajesh Jha** added that his own mother delayed disclosing symptoms of spotting due to discomfort, even in a household with medical professionals. Malignancy was detected late. He emphasised the importance of screening and noted that clinicians are currently being trained in VIA, as many had not conducted it previously.

Dr A.K. Garg reflected on how Indian women are conditioned to be quiet and sacrificing. Even in educated households, women delay eating, rest, and care-seeking. His mother's symptoms were dismissed until her TSH was found to be 28. He highlighted osteoporosis and vitamin D deficiency as overlooked but devastating conditions.

Following this **Dr Shivangi Shankar, Manager, Inclusive Health Systems, PCI India** presented learnings from Jehanabad, as well as previous iteration of the dialogue and other field findings. The discussion was anchored in the recognition that women tend to live longer than men, yet globally spend 25 more years of their lives in poor health.[1] In India, women typically complete childbearing by ages 27-28, and often earlier in states such as Bihar. After this point, attention to women's health drops sharply- from families, from society, and from health services.



Majhdhaar has therefore been intentionally framed as beyond maternity, rather than age-based, recognising that many health issues begin earlier but remain unaddressed due to normalisation, neglect, poor body literacy, financial constraints, and lack of decision-making power. Majhdhaar focuses on women who are “somewhere in the middle,” currently unable to move forward and at high risk of further decline without support.

Women's care-seeking journeys are rarely linear. They often begin with waiting and rationalisation: “Ate too much at night.”; “Got better on its own.”; “Everyone has it.” Seeking care frequently requires permission from husbands or in-laws, particularly in contexts of migration. Initial care is often limited, with minimal examination at the village level. Women are then asked to travel to Gorakhpur, Lucknow, or Delhi — often without money for travel.

Familiarity and ease of access push women towards untrained practitioners because “he is the easiest to go to.” Over time, women spend tens of thousands of rupees, exhaust savings, or take loans. Health cards “didn't help.” Repeated encounters without physical examination led to loss of trust. Women continue to suffer. Some undergo surgery, but post-operative rest is compromised. Symptoms persist. Fatigue, pain, and bleeding are normalised again. “Everyone has it... How long can I keep trying?”

These journeys are not exceptional; they are patterned.

The session highlighted that women are often not allowed to fall ill and adopt the “sick role”. Ordinarily, illness involves rest, care, and escalation to medical attention. For many women, this sequence is unavailable. Women carry the burden of proof, even in medical settings. Thus, delays accumulate and are embodied over time.

A central goal of the initiative is to lower the threshold of care-seeking-- not only medical care, but also rest, diet, and community care.

Dialogue I: What the Data Says (and What It Doesn't)



Dr Ruma Sarkar, Professor and Head, Obstetrics & Gynaecology, BRD Medical College grounded the discussion in routine clinical practice, drawing attention to the persistence of anaemia despite years of programmatic focus. She stated that 50-60% of women presenting to outpatient departments continue to be anaemic, despite government schemes and sustained IFA supplementation.

Women's health was described as consistently deprioritised within households, with care-seeking often delayed until symptoms become severe. Antenatal visits were observed to be centred on confirming foetal wellbeing through ultrasound, while blood tests for women themselves were frequently avoided. Even when iron tablets are provided free of cost through ASHA workers and Anganwadi centres, adherence remains low. Abnormal bleeding was described as widely normalised, with care sought only when bleeding becomes unmanageable. Emerging patterns were also highlighted, including increasing cases of PCOS among young girls and rising infertility associated with delayed marriage.

She noted, menopausal symptoms were routinely dismissed as “physiological,” resulting in delayed care. She expressed particular concern regarding the overuse of hysterectomy, including among young women. It was noted that even simple ovarian cysts are sometimes treated surgically, occasionally on the advice of qualified doctors, reflecting gaps in clinical confidence and practice. She highlighted the need for special consultation and care especially in the case of surgical menopause.[2]

Dr Pradeep Kharya, Associate Professor, Community & Family Medicine, AIIMS Gorakhpur discussed how the Health and Demographic Surveillance System (HDSS) at AIIMS Gorakhpur is a platform for addressing gaps in life-course data. The HDSS covers rural Dumri Khas and urban Shivpur, with baseline data from approximately 60,000 individuals, including around 11,000 women aged 30 years and above.



The value of longitudinal cohort data was emphasised for understanding disease trends, health-seeking behaviour, and health inequalities. Differences between urban reliance on private tertiary care and rural dependence on non-qualified practitioners were highlighted as shaping divergent health outcomes. Beyond morbidity, the HDSS captures social indicators such as school attendance, expected age of marriage for adolescent girls, maternal mortality and morbidity, gender inequality, early marriage, and chronic illness among women. The inclusion of verbal autopsy in the second phase was noted as strengthening understanding of mortality pathways.

Such cohort platforms were positioned as essential for designing more targeted and streamlined interventions, particularly in the context of Majhdhaar's life-course focus.

[2] <https://www.fogsi.org/wp-content/uploads/announcements/Guidelines-and-Reportings-of-Hysterectomies.pdf>

Dialogue II: Designing for Women’s Wellbeing — Imperatives and Constraints

Dr Raj Shankar Ghosh, Public Health Expert, emphasised the importance of respectful engagement with private providers, noting that meaningful collaboration requires listening to their experiences and integrating evidence into programme design. Four areas of private sector contribution were identified: improved access where public services are limited; marketing dynamics that shape demand and client satisfaction; holistic approaches spanning the life cycle; and strengths in monitoring, evaluation, and documentation.

The potential role of artificial intelligence and digital tools was highlighted, particularly technologies currently used for awareness generation and marketing, which could be adapted for learning and NCD monitoring if designed appropriately.

Dr Till Bachmann, Principal Investigator, DOSA Project[3] framed the DOSA project through women’s everyday experiences of recurring UTI symptoms, locally described as *tatrangi*. *Tatrangi* was not mapped to infection in the local imagination. These experiences were characterised by difficulty leaving home high costs of medicines, distant health facilities, and multiple barriers to care. Low awareness of UTIs and antimicrobial resistance, discomfort in seeking care, and the failure of diagnostics located only at primary health centres to reach women were identified through work in rural Assam. A co-design approach was therefore adopted, working with ASHA workers, households, and pharmacists.

The resulting diagnostic bundle combined guidance, paper-based diagnostics, and data capture, designed to be low-cost, easy to use, and environmentally stable in high-temperature, high-humidity settings without cold-chain access. It was emphasised that technology is ineffective if it does not reach communities.

Recurring UTIs were highlighted as being frequently dismissed as “uncomplicated,” despite years of suffering reported by women. Trust-building was described as a slow process, requiring patience from funders and implementers alike.



Dr Anand M. Dixit, Professor and Head, Community & Family Medicine, AIIMS Gorakhpur questioned the sharp distinctions often drawn between rural and urban women’s health. While acknowledging differences in affluence, he argued that most women face similar constraints related to access, affordability, and weak support systems. He emphasised the importance of empathetic care at the Community Health Officer (CHO) level, noting that trust built at this level can influence broader community engagement. He also stressed the need for family-shared responsibility, particularly the involvement of husbands in women’s care. Dr Dixit cautioned against an over-reliance on digital IEC materials and instead advocated for community-based communication and focused pilot models that can be evaluated and refined.

Anila Hritu, Community Health Specialist, Women's Wellbeing Initiative, PCI shared learnings from SHG-based work in Jehanabad, where women initially lacked vocabulary to articulate genitourinary symptoms, resulting in widespread normalisation and neglect. A body literacy picture tool was developed to support women in understanding and communicating about their bodies and health. In the first phase, community cadres were trained to identify symptoms using structured formats. Of the 1,739 women reached, 64% were identified with genitourinary symptoms. Follow-up was possible for approximately two-thirds, and nearly three-quarters of those were successfully linked to health facilities.



Ongoing challenges included women's uncertainty about where to seek care, prompting efforts to map health facilities and providers for community use.

Shifts towards preventive behaviours were also noted, alongside instances where improved spousal communication enabled women to seek treatment. It was pointed out that spousal communication was an essential part of such packages and excluding men from such initiatives could endanger the progress made. Anila agreed saying, we must change them from gatekeepers to gate openers.



Indrajit Chaudhuri, Country Director, PCI India outlined key priorities for improving women's wellbeing during the Majhdhaar phase. He emphasised that recognition of health problems — by women themselves, husbands, and families — is the most critical starting point.

He stressed the importance of addressing low-hanging clinical and screening needs using existing treatments, citing tranexamic acid for heavy menstrual bleeding as one example. Public-private collaboration, he argued, is essential for protocol development and diagnostic access.

Reflecting on decades of RCH work, he noted that declining mortality has created space to focus on morbidity and quality of life. He highlighted nutrition beyond maternity as a priority and described mental health as an important but more complex area for phased engagement

Dialogue III: The Journeys of Illness — Where Can We Step In?

Dr Anil Koparkar, Additional Professor, Community & Family Medicine, AIIMS Gorakhpur emphasized, all the issues being discussed were mere symptoms of a social disease. We require intervention at different levels- at individual level- women should recognize that their health is their right and their responsibility as well.

He pointed out that at the primary healthcare level even when women are supposedly in the radar of the healthcare services, women don't get registered for themselves- they register either for their children when they are pregnant or if

their productivity is low, they're always the "secondary" patient. The primary patient is always someone else. We need to change that.

Dr Koparkar also highlighted the Majhdhaar within the Majhdhaar—categories of women who are often missed entirely—older unmarried women, women not seeking pregnancy, working women absent at homes, the locations of investigation, during surveys, and older women living alone- all of whom are at high risk of dropping out of care and visibility.



Dr Shikha Seth, Professor and Head, Obstetrics & Gynaecology, AIIMS Gorakhpur, highlighted missed opportunities across the care continuum, noting that while women visit health facilities at multiple stages of life, care often remains limited to immediate symptoms: okay, they have pain... let's give this medicine, let's give this antibiotic...80% of cases are like this only; actual clinicians do this and even quacks do this since they've learnt from the clinicians. We don't pay attention to the common issues like urinary and genital illnesses. It's not that women never visit healthcare facilities, they do. We need to use the opportunity.

The need for opportunistic screening whenever women present at facilities was emphasised, alongside the involvement of family members during consultations to support adherence and follow-up. Strengthening primary screening skills among CHOs and frontline workers was identified as a priority.

Dr Uma Singh, Senior Technical Director, Maternal Health, IHAT highlighted persistent gaps in facilities below the district level, including shortages of trained human resources and limited quality monitoring. While infrastructure improvements were acknowledged, preventive health was described as receiving insufficient attention.

Anaemia was characterised as a multi-pronged issue that cannot be addressed through parenteral iron alone. Why should we need to depend on parenteral iron? We must focus on prevention. Prevention was emphasised as needing to begin in childhood, through strengthened schools, nutrition, hygiene, and lifestyle interventions.

It was noted that without sustained investment in public health and prevention, disease burden will continue to rise, increasing pressure on drugs, human resources, and healthcare services.

Syed Adeel Abbas highlighted convergence opportunities beyond the health sector, particularly with the rural development ecosystem. DAY-NRLM's presence across 75 districts in Uttar Pradesh and its extensive SHG and Village Organisation networks were noted as critical platforms.

It was emphasised that poverty eradication goals cannot be achieved without improving women's health. With over 30,000 health sakhis working through SHGs, opportunities were identified to address anaemia, mental health, and social norms alongside service delivery.

From Description to Action: Next Steps

The Majhdhaar Dialogues concluded with agreement on specific, actionable commitments to advance women's wellbeing beyond maternity, grounded in existing institutional mandates and platforms. An MoU was signed between ICMR–RMRC Gorakhpur and PCI India to formalise collaboration combining community-led research and documentation of lived experiences with scientific guidance, epidemiological inquiry, ethical oversight, and evidence translation. Model Rural Health Research Units (MRHRUs) will be explored as sites for piloting screening and check-up interventions for women beyond pregnancy, with learnings used to develop protocolised approaches and intramural project proposals.



Strengthening the capacity of Community Health Officers and ASHAs emerged as a priority, alongside a shift towards routine and opportunistic screening using simple tools and OPD checklists that capture social determinants and enable follow-up. Commitments also included strengthening life-course evidence through HDSS and other cohorts, investing in body literacy and community engagement via SHGs and VHSNCs, and leveraging DAY-NRLM platforms for convergence at scale. Initial efforts will focus on well-documented pilots, with an emphasis on iterative learning rather than one-time implementation.



MAJHDHAAR

Nurturing Women's Wellbeing Beyond Maternity



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