Chapter 9

Gender and Health

In the course of deliberations of the High Level Expert Group, the issue of gender arose repeatedly. Considerations of gender equity are integral to our understanding of Universal Health Coverage (UHC) and explicit across various recommendations. Yet, this chapter separately appraises the situation in India with respect to gender, and in turn, highlights the particular ways in which the UHC framework will both strengthen and be strengthened by gender equity. This is a reflection of the special attention that we feel gender requires as we move forward with our vision for health reform in India.

1. Introduction

Until recently, 'gender in the context of health' implied a discussion on women's health. However, an inclusive approach to health should attend to the needs and differentials between men, women and other genders, along with the interaction between social and biological markers of health.[1] In order to attain such universality in health coverage, it is essential to achieve gender equality (the equal enjoyment of good health by men and women of all ages regardless of sexual orientation or gender identity). This may be ensured through gender equity (the process of being fair to the different health needs of men, women and other genders), gender mainstreaming (making men's and women's health concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of health policies and programmes) and empowerment (enabling individuals and communities to gain more control over their lives and to shape systems around them).[2] A gendered perspective would thus take into account the health needs of all categories of sexual identity; "heterosexual, homosexual, lesbian, gay, bisexual, 'queer', transgendered, transsexual, and asexual."[3]

The very framework and principles of UHC for India will be severely undermined if gender insensitivity and gender discrimination remain unaddressed. Gender disparities, particularly persistent in anti-female biases, are most glaringly reflected in the declining female-to-male ratios among children below six (with the sex ratio among children declining from 927 girls per 1,000 boys in 2001 to 914 in 2011).[4] The World Economic Forum ranked India as 132nd out of 134 nations in terms of gender equity in health.[5] Furthermore, there remains a disturbingly high Maternal Mortality Ratio (MMR) of 212 maternal deaths per 100,000 live births,[6] despite the country's rapid economic growth rate.[7]

2. Burden of Disease

A difference between the genders is apparent in risk factors and disease burdens across the lifecycle, from childhood, through adolescence and adulthood, to old age.[8,9] We present some examples of these life-cycle burdens as well as those that are hidden or understudied.

Childhood: Data from NFHS-3 revealed that in 2005-06, while neonatal mortality rates were higher in boys, post-neonatal mortality rates were higher for girls, demonstrating that gender discrimination leading to inadequate care nullified the girl child's biological advantage over boys during the first few years of life.[9] Gender disparities are also seen in nutrition with persistently high levels of anemia among girls and women, and in immunization rates, where girls are significantly less likely to be fully immunized than boys.

Adolescence: Complications during pregnancy are the leading cause of death among 15-19 year old girls in India. Early marriage and child-bearing can pose

several additional health risks, including pregnancy-related complications, unsafe deliveries, improper prenatal and postnatal care and miscarriage.[10] Mental health problems associated with puberty, identity crises, and role transitions also constitute a large proportion of the burden for adolescent girls.[11] Occupational hazards due to physical labour and domestic work (especially in agricultural areas) can be particularly damaging for the underdeveloped and undernourished adolescent girls in rural areas.[12] Gender differences are also apparent in tobacco use, with 33.2% of Indian boys under the age of 15 years smoking tobacco, compared to 3.8% girls under the age of 15 years in 2006.[13]

Adulthood: Studies indicate that anemia (iron deficiency) affects 50-90% of pregnant women in India, and significantly increases the risk for maternal deaths due to hemorrhage.[11] Significant health complications also arise due to unwanted pregnancies and subsequent unsafe abortions. A gender bias is seen in the way reproductive health and sexual health are considered as exclusive health needs of women and men respectively. For instance, reproductive health services are targeted towards heterosexual women who are, or will be, mothers and therefore the Reproductive Health Programme for women. Sexual health services, especially in relation to HIV/AIDS, are considered needs of men, and hence the National AIDS Control Programme. These kinds of gender biases need to be addressed during the sensitization and training of healthcare providers as well as while designing Essential Service Packages for men and women, including for persons of diverse sexualities.

Old Age: In India, the life expectancy at birth is 66 years for women and 63 years for men, however this longevity brings with it a considerable burden of disease for elderly women.[13]Women over 60 years tend to have greater disability and more co-morbidities than men of the same age-group, which may be due to biological factors such as lower muscle strength and bone density in women compared to men[14, 15], as well as social factors such as restricted access to nutritional food and healthcare facilities across the lifespan. Heart disease causes more deaths in older women than men, however women are less likely to seek or receive appropriate and timely care for the condition, and are often under represented in cardiovascular risk research.[14] A considerable health burden for women in this age group is experienced due to neuropsychiatric conditions, especially dementia and depression. Other conditions during this period include loss of vision, cancers, osteoporosis and arthritis.[14]

Hidden Burden of Disease: Women are afflicted with a considerable hidden burden of disease which is often not accounted for in morbidity figures. Evidence indicates that there is a trend towards the growing burden of non-communicable diseases, in India and the world.[16, 17] In a review of Indian studies, Davar found that women are twice as likely to suffer from common mental disorders as men,[18] which is supported by global prevalence rates.[19] Violence against women remains high in India and a study by INCLEN reported that 40.3% of the women sampled reported at least one instance of physically abusive behaviour in their lifetime.[20] A report by WHO-SEARO discusses how suicide, an extreme manifestation of these hidden burdens, is now a leading cause of death among young women in India and China.[21]

Marginalisation from the health system occurs in intersections; i.e. health status overlaps with social status, employment, and gender. This is the case for other vulnerable populations as well, such as those from SC/ST populations, and religious minorities. In healthcare settings in particular, transgendered Indians have had to face discrimination on the basis of transgender status, sex work status, HIV status, or a combination of the aforementioned.[22]

3. The Rationale for a Gender Perspective in the Indian Context

There are variations in the way public health policies in India define, depict and prioritize issues related to gender and health, particularly among the poor and marginalised. Examples include population control policies like the two-child norm, the neglect of safety in childbirth by promoting hospital births without addressing issues of quality or the reality of home births, research trials on tribal girls for vaccines for cancer prevention without parental consent or resources for screening, lack of guidelines for transgender populations seeking healthcare and varying efforts towards ensuring comprehensive sex education and body literacy in schools. Women are also targets of provider-centric population control and disease control policies like injectable contraceptives, oral contraceptive pills, hormonal drugs, fertility regulators, and intrauterine devices (IUDs). Very little is known about the post-reproductive effects of drugs (such as menopause, menstrual regulators, and hormone replacement therapy) on the metabolism of women.

Moreover, the health sector is one that absorbs the highest number of women, largely because of their socially prescribed role as carers. A large proportion of the women in the public health system in India are employed as frontline workers – Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs), Anganwadi Worker (AWWs), and Nurses. Comparatively, the proportion of women in health policymaking and in health management positions is very low. Even when women are in management positions (for example the Directors of Nursing and Nursing Administrators), within the health sector, the hierarchy between Doctors and Nurses is such that women have less power and leverage than men. Therefore, recommendations for Universal Health Coverage (UHC) should take into account the needs of women employed in this sector. Furthermore, under UHC, the definition of 'maternal health' needs to be expanded beyond childbirth in hospitals to include nutrition, wage loss entitlements, breastfeeding support in the workplace, and services for maternal morbidities.

It should also be ensured that programme design prioritises approaches to service provision that are non-coercive, based on safe choices and that adopt a rights-based approach. Sex and gender differences - for example, higher depression amongst women and higher substance abuse amongst men, or the fact that while prevalence of malaria amongst men is higher, its consequences for pregnant women can be fatal – need to be factored into the design and content of services for women and men.

Another key issue is access to health services for vulnerable genders. Access is severely reduced by neglect that stretches from the family to the healthcare provider especially for life-saving obstetric care, reproductive and sexual health services for girls, women and transgenders, along with poor health education and awareness for all sexes.

There are several barriers to the provision of and access to these services, which should be factored in while framing recommendations for UHC. These include:

a) **Political and legal barriers** such as the misplaced emphasis on population control policies while fertility rates decline, the lack of political will for sexuality education and gender-sensitization;

b) **Economic barriers** such as user fees for maternal health services, the burden of healthcare loans repayment for poorer families, and the dearth of affordable public primary care services, which makes inevitable the use of private tertiary services;

c) **Social barriers** such as stigma attached to certain illnesses such as HIV/AIDS (especially for men who have sex with men who face greater social and epidemiological risks) and depression (higher among women and access to services lower); and

d) **Health system barriers** such as the shortage of human resources for health, lack of gender

sensitization among healthcare providers and lack of linkage and integration in current provisioning, which lacks primary care and rural coverage, as well as a lack of awareness of the provisions of the various schemes and programmes for women.

4. Recommendations for Gender and Health

While the country's health system has a considerable distance to go in order to become truly gender-sensitive, important steps need to be taken in the following core areas in the move towards Universal Health Coverage:

- Acknowledging gender diversity through the life-cycle during the conceptualisation and delivery of services;
- Improving access for women and other vulnerable genders;
- Recognizing the key role that women play as formal and informal providers of health services and empowering them for that role;
- Strengthening data, analysis, and monitoring & evaluation systems in order to make them more gender sensitive; and
- Supporting and promoting the rights of girls and women to health in families and communities through programmes and policies.

In making UHC truly gender-sensitive, we specifically recommend critical actions in the following four areas.

Recommendation 1: Improve access to health services for women, girls and other vulnerable genders (going beyond maternal and child health) by:

- Using a life-cycle approach that allocates greater financial and human resources to nutritional anaemia, broad sexual and reproductive health (including RTIs, STIs, safe abortion, contraceptive care, uterine prolapse, menstrual disorders, malaria and tuberculosis during pregnancy), domestic and gender-based violence, and critical mental health services (especially for depression);
- Identifying and responding to occupational health and work-related health issues in a gender sensitive manner;
- Adjusting the location and timing of health service delivery at all levels to be responsive to women's multiple work and time burdens, lack of mobility, and transport costs; and
- Training health providers to be responsive to the specific needs and concerns of girls and women, and to improve their interactions with poor and marginalised communities.

Recommendation 2: Recognize and strengthen women's central role in healthcare provision in both the formal health system and in the home by:

- Improving working conditions for women workers especially by addressing their concerns about safety, transportation, housing, and hygiene and sanitation. Moreover, maternity benefits, career re-entry prospects for women who have been out of work due to motherhood, addressal of sexual harassment issues, and the need for within-district appointments also need to be factored in;
- Expanding women's career trajectories through time-bound programmes to increase the number of women in higher positions in health management;
- Ensuring that all health management structures have mandated representation of women professionals including nurses; and
- Providing for community based care programmes such as day care centres, palliative care, domiciliary care, and ambulatory care that can support home based healthcare provision.

Recommendation 3: Build up the capacity of the health system to recognize, measure, monitor and address gender concerns through improved data gathering, analysis, monitoring and evaluation by:

- Ensuring that all health data (whether collected through the Ministry of Health and Family Welfare, the centralized statistics collection systems such as the National Sample Survey, the states, or by others such as the National Family Health Survey) are disaggregated by sex and age; and are reported and analysed on these bases;
- Supporting the major resource centres for health analysis such as the National Health Systems Resource Centre, State Health Systems Resource Centre, National Institute of Health and Family Welfare, State Institute of Health and Family Welfare and others to build their capacity for gender analysis;
- Requiring monitoring and evaluation systems (including, for example, the annual Common Review Missions under the National Rural Health Mission) to address performance on the basis of gender through clearly developed criteria and indicators; and
- Accounting for unpaid, home-based healthcare in the National Health Accounts so as to arrive at a realistic estimate of the contribution of households and women to the health sector.

Recommendation 4: Support and empower girls, women and other vulnerable genders to realize their health rights through:

- Sensitization programmes for all young people that include key elements of health, gender power relations and their health consequences;
- Removing conditionalities (specifically two-child norms for maternity or other benefits) from all health programmes so as not to punish women and girls for behavior over which they have little or no control.

(Note: More detailed recommendations and situational analysis, is provided in a Background Paper on Gender and Health by Ms. Renu Khanna, Ms. Manasi Sharma, Dr. Devaki Nambiar and Dr. Priya Balasubramaniam)

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