Towards Gender Responsive Primary Health Care

Key Recommendations

- Gender sensitization and capability building on gender for stakeholders, including policy makers (government officials engaged in policy formulation and program design and delivery), all cadres of health care providers, and public health professionals.
- Establish a gender cell in each Ministry.
- Ensure that all health programs incorporate a gender perspective.
- Include gender considerations in all demand generation strategies and related training with frontline workers, allied health professionals and medical doctors at all levels of health facilities. Approach medical councils to discuss how gender can be integrated into medical education.
- Involve the private sector by reaching out to Medical Associations and Preventive and Social Medicine Departments in hospitals.
- Gender training should not be a standalone activity, but should be integrated into ongoing training for various programs.
- Learn from smaller community initiatives that have conducted gender sensitization trainings for their outreach workers and adapt what is relevant to sensitize the various cadres of health care providers.
- Promote more research in Gender Sensitivity. Inclusion of gender sensitivity must be done carefully and thoughtfully in pre-service and in-service training environments.
- Promote research to show that integrating gender into health programs confers long term benefits.

India’s mandate for Universal Health Coverage (UHC) proposes to ensure “equitable access for all Indian citizens... to affordable, accountable, appropriate health services of assured quality...as well as public health services addressing the wider determinants of health” (HLEG Report 2011). The High Level Expert Group (HLEG) UHC report underscores two key considerations for the achievement of UHC: gender and social determinants of health. The HLEG report asserts that,

“the very framework and principles of UHC for India will be severely undermined if gender insensitivity and gender discrimination remain unaddressed.” At the very outset the HLEG acknowledges the central role of gender equity in making an impact on the effort to reduce ill health and disease, in accessing and utilizing health care, as well as in the delivery of health care services. Gender considerations are vital in the design, delivery, and uptake of UHC.

The term “Sex” refers to the biological and physiological characteristics that distinguish men from women. Gender, on the other hand, is a social and relational construct which impacts the relationships between women and men, individually, in families and in the larger community. Gender relates to attributes, behaviours, roles, and activities that a society considers appropriate for the male and female sex. Gender norms and roles differ from society to society; in order to promote gender equity, interventions such as UHC must seek to understand how gender in a given sociocultural, economic context can preclude the attainment of good health.

Sex, drives differences between women and men in terms their biological and/or genetic vulnerability to health conditions and diseases; gender compounds this vulnerability in terms of, health seeking behaviours, how a disease is presented, diagnosed and treated, access to and utilization of health services and, ultimately, health outcomes. Gender also intersects with other key socioeconomic variables such as caste, class, religion, educational and marital status further impacting health outcomes.
Gender Project at PHFI

With support from the Royal Norwegian Embassy, the Public Health Foundation of India (PHFI) conducted a study to understand the gendered dimensions of health care delivery, with a focus on primary health care. The premise of our project is that while adverse health outcomes, in part, result from differences in service delivery and use by men and women, such inequalities may also stem from the way in which the delivery of health services are planned or formulated. Therefore, gender inequalities may be addressed by targeted actions, in the same way that other inequalities in society are being tackled. The Gender project intends to inform and stimulate discussions around such interventions.

Methodology

This exploration was guided by expert consultations, of policy and program documents, and Key Informant Interviews with health and gender experts. Key national policies on health and three national health programs were examined in detail. National policies include National Health Policy, National Population Policy, National AIDS Control Policy, National Rural Health Mission, and the 12th Five Year Plan. National programs assessed were the Reproductive and Child Health Program (RCH), the National AIDS Control Program (NACP) (all phases), and the Revised National Tuberculosis Control Program (RNTCP). An overview of the methodology is given in Figure 1.

Objectives

The overall aim of this study is to recommend how gender may be integrated into primary health care services in India. The specific objectives of this study were:

1. To assess how national policies related to health in India conceptualize and include gender.
2. To assess how key national health programs operationalize gender considerations in the design and delivery of health services.
3. To identify how gender considerations may be incorporated into policies and programs in India to improve the delivery and utilization of primary health care services.

Literature Review

In order to examine the gender dimensions of policies and health programs, we first undertook a literature review to identify gender assessment and gender analysis frameworks used for the formulation of these policies and programs. Based on this review, we developed a gender assessment criteria used for selected Indian policies and health programs. We categorized health policies and programs along a gender responsive continuum in Figure 1.2. We also conducted a literature review of gender mainstreaming approaches. We organized gender mainstreaming approaches using the World Health Organization’s (WHO’s) Health Systems Building Blocks Framework.  

Figure 1: Overview of Methodology

- **OBJECTIVES**
  - To assess how national policies in India conceptualize and include gender
  - To assess how key national health programs operationalize gender considerations in the design and delivery of health services
  - To identify how gender considerations may be incorporated into policies and programs in India to improve the delivery and utilization of primary health care services

- **METHODOLOGY**
  - **Literature review**
    - Gender assessment/analysis criteria
    - Gender mainstreaming in India and Internationally
  - **Document review: International Treaties and agreements**
    - Convention to Eliminate all forms of Discrimination Against Women (CEDAW)
    - International Conference on Population and Development (ICPD)
    - Beijing Conference
    - Millennium Development Goals
    - Post 2015 Development Agenda
  - **Document review: National Policies**
    - National Population Policy
    - National Health Policy
    - National AIDS Control Policy
    - National Rural Health Mission
    - 12th Five Year Plan
  - **Document review: Health Programs**
    - Reproductive and Child Health Program
    - National AIDS Control Program
    - Revised National Tuberculosis Control Program
  - **Key informant interviews**
    - With 10 health and gender experts in India

1 The WHO Health Systems Framework is available at http://www.wpro.who.int/health_services/health_systems_framework/en/index.html
Findings

International treaties and covenants, such as CEDAW, ICPD, Beijing Conference, and the MDGs engender a rights-based approach to development and health, emphasizing equity and equality as central to overcoming development challenges. These frameworks can powerfully shape national level policies and health programs in India, thus policy makers must explore how these frameworks can be translated into practice to facilitate and sustain desired health impacts, especially since India is a signatory to these treaties.

The common thread across the national level policies reviewed is the emphasis on improving access to, and delivery of, health services. To this end, the policy documents uniformly mention women, children, poor and rural populations as groups requiring additional attention, and the need to enhance the capacity of the health system to meet the needs of these groups. These policy recommendations are valid and reflect a desire to fill the lacunae in the health system. Yet equity considerations, including gender, are not expressed and linked together across the various aspects of service delivery, undermining the health system’s ability to achieve the desired and sustainable improvements in health. International treaties and national policies related to health and development have favourably impacted health interventions through national level programs such as the Reproductive and Child Health (RCH I and II ) Program and the National AIDS Control Program, as well as more stringent enforcement of Acts that serve to promote and protect the rights of girls and women, such as the Medical Termination of Pregnancy (MTP) Act (1972) and the Pre Conception and the Pre-Natal Diagnostic Techniques (PCPNDT) Act (1994). However, gender considerations are often operationalized through policies and programs oriented towards girls and women and maternal health, overlooking the health needs of men, and other health conditions that may differently impact men and women. Another issue is while policies propose a gendered approach, they offer little guidance on what this gendered approach should look like – except for the NACP, which makes some effort to articulate this.

RCH, NACP, and RNTCP are among the largest health programs in India. They address major health concerns reflecting India’s commitment to achieving the MDGs related to improving maternal and child health, and fighting HIV/AIDS and TB. An imperative that underlies the achievement of these goals is the promotion of gender equality and women’s empowerment. We find that RCH, NACP, and RNTCP unintentionally underestimate the gender dimensions of health, though to different degrees. Gender inequalities compound an individual’s biological vulnerability to poor health by influencing how a person understands, experiences, and responds to health needs and diseases. For health programs to be successful, they need to be aware of and respond to the different health needs of men, women, and other genders.

A gender blind program overlooks how gender norms, roles and relations impact health, health seeking behaviour, health outcomes, and the provision of health care. When a program is blind to gender it ignores how men, women, and other genders have different access to resources and opportunities to maintain and promote health and to seek care when sick. The RNTCP is an ideal example of a gender blind program. RNTCP emphasizes universal access to TB control and treatment services and appears “equitable”. Yet this approach treats everyone as having the same health needs. There are significant gender differences in TB. To be truly equitable and to ensure universal access to TB control and treatment services, RNTCP needs to actively consider and address the unique barriers that both men and women face in recognizing TB symptoms, seeking diagnostic services, and receiving and adhering to DOTS. A gender specific program, in contrast, acknowledges that in society, men and women have distinct health needs, and that gender roles, norms, and relations mediate their access to, and control over, resources to access health care. In response, gender specific programs intentionally target specific groups to address their specific health needs. The RCH and NACP programs exemplify this approach. The RCH program is focused on women with the aim of providing them with essential reproductive health services. Such efforts are much needed in a patriarchal society.

Figure 1.2: Gender Responsiveness Continuum

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<td>• Power imbalances</td>
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where women’s freedom (in terms of mobility, interactions, and access to resources and opportunities) is restricted. Yet, with its focus on women, specifically their reproductive roles, it reinforces women’s traditional responsibilities in society. Further, with limited male engagement in family planning and maternal care, the program does little to challenge the social norms that drive gender inequalities. The NACP, too, is gender specific in its approach. It targets groups that are at most risk for HIV/AIDS and provides them with essential preventive, promotive, and curative services, but is unable to address the underlying factors that place women, men, and other genders at risk for this disease. The gender equity and social equity strategy however provides opportunities for NACP to move towards a more responsive strategy, by creating an enabling environment, and tacking the underlying social factors that compound HIV vulnerability.

Health programs need to be responsive to gender. This means that they understand how gender impacts health, and also take action to challenge and change gender inequalities. This is an evolving goal as our understanding of gender’s relationship with health changes with more research in this area. Periodic reviews of literature on gender and health programs can offer valuable insights into gaps and strengths. We recommend exploring, understanding, and testing strategies such as gender mainstreaming to offer guidance on how health program components may be more responsive to gender needs.

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