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Comprehensive Health Care! Where Do Women Stand? – A Policy Analysis

Senthil Arasi. D	Assistant Professor, Department of Community Medicine, ACS Medical College and Hospital, Chennai.
Vijaiyalakshimi Praveen	Assistant Professor, Department of Community Medicine, ACS Medical College and Hospital, Chennai.
Shalini. A	Assistant Professor, Department of Community Medicine, ACS Medical College and Hospital, Chennai.
Subhashini. R	Assistant Professor, Department of Community Medicine, ACS Medical College and Hospital, Chennai.
Rajkamal. R	Assistant Professor, Department of Community Medicine, ACS Medical College and Hospital, Chennai.
Kalyan Kanti Duttagupta	Professor and Head, Department of Community Medicine, ACS Medical college and Hospital, Chennai.

ABSTRACT

Background: *It is well known that men and women have different kind of illness not only because of their biological difference but also because of the relative environment they live in, social and cultural practices, activities and role they play in the society. Men and women have different health outcomes for same illness and one of the major reasons is restriction to access formal health care. Health policies have evolved for the better, still there are some issues that are to be addressed to and this paper tries to take a second look at the health policy planning in the country since independence and to analyse the encumbrance in accessing health care for women in our country.*

Methodology: *Review of health policy and planning and Application of Gender analysis using Liverpool framework*

Result: the major limitations in acess to health care for women were found to be timing of health centers, non availability of services near the residence with gender insensitive health care providers at all levels, high cost of health care

Discussion: *Socio-economic status combined with lack of access and control over resource plays a major role in accessing formal health care for women; hence we need a mechanism in the community to help women help themselves.*

Conclusion: *Government needs to make health system reforms in financing and regulatory mechanism of health care. These reforms have to be gender sensitive and need more women representatives at the policy making level and all policy maker need to be gender sensitive on the decisions they make.*

KEYWORDS : Gender, health care, health policy, critical review, gender analysis

Introduction

India after the Alma-ata declaration in 1978 adopted the "Heath for all" by 2000 A.D. policy and formulated its first National Health Policy in the year 1983 to put this into action it used primary health care services, as its main tool (1). The primary health care which talk about comprehensive health care services for women had strong component for maternal and child health and disregarded the fact that women's health is not related to only child bearing. As the population of females in India is 50% and investing in these 50% of population is investing on not only the entire 100% but also the future. Though the health policies have evolved for the better, still there are some issues that are to be addressed to and this paper tries to take a second look at the health policy planning in the country since independence and to analyse the encumbrance in accessing health care for women in our country.

Review of Health Policy Planning and programme for women in India

Even though there was no national health policy in India until 1983 it had its first planning for health in the year 1950 (first five year plan). And the main emphasis was to reduce the population and hence on reduction of birth rate, so the target, needless to say – women of reproductive age. The government was explicitly not aware or should I say insensitive to the gender issues, when it launched the national family planning programme, though the argument then was that the women at young age were dying due to pregnancy related causes and by curbing on the number of pregnancy would reduce the number of women dying at young age (2). But the government foresaw the reasons why women died due to pregnancy related causes, it was simply because most women did not have access to even minimal maternal health care at that time. Women in the urban set up alone had some access to health care facilities. Even though the Bhore committee advised for a comprehensive primary care with emphasis on mother and child welfare in 1946 India launched the Family Planning programme with the main aim of birth control in 1951(3).

Following the family planning programme there was the family welfare programme then the maternal and child health programme (4). All these programmes were concerned more about numbers, the quantitative aspect i.e. number of IUD insertions, number of sterilizations etc., until the child survival safe motherhood (CSSM) programme which turned the attention towards the quality aspect of the care given but there was no proper implementation. (5). All most all the programmes meant for women were primarily aimed at population reduction; this even includes the Reproductive and child health programme (RCH) (6,7).

RCH is an extension of CSSM that speaks about life cycle approach and two components that were not there in CSSM- RTI and STI care, and adolescent health were introduced in RCH programme (8). RCH has the ideological perfection of the concept of comprehensive health care "from womb to tomb" and this was largely because of the vigor from the resolution made

in the United Nations International Conference on Population and development (ICPD), Cairo, 1994 that addressed issues like gender equality, equity, women empowerment, reproductive rights and reproductive health (9). Despite the ideological perfection of the programme there are a lot of practical lacunae like lack of gender sensitive training to health care provider at all levels right from the medical officer to the grassroot level workers (male and female multi-purpose workers). Despite the fact that some states in India are facing demographic and epidemiological transition which has left women with long life in post reproductive age having menopausal problems, non communicable diseases leading on to a shift in morbidity pattern in women, from reproductive age to post reproductive age, there is no proper provision for delivery of health care for older women who don't belong to the reproductive age group and non-obstetric health problems of women. Amidst the enthrallment for the population reduction the policy makers neglected some of the important aspect of health care sector like the availability, affordability, accessibility, acceptability and quality of the health system. Even till this day most women in India don't have access to affordable, quality health care and this is one of the reasons for poor health indicator in the country despite its economic progress.

Gender Dimensions in Response to Ill-Health

It is now well known that men and women have different kind of illness not only because of their biological difference but also because of the relative environment they live in, social and cultural practices they follow, activities and role they play in the society. Men and women also have different health outcomes for same illness and one of the major reasons is restriction to access formal health care at different levels – household, community and national/international levels. Again the inaccessibility to health care is due to a number of reasons: affordability, physical accessibility, perceived need for health care by the women and her family, economic reasons.

Results: Application of Gender analysis (Liverpool) framework

A woman has a lot of restrictions at all level to access formal health care at the appropriate time. These restrictions are directly related to her role, activity, environment, bargaining position, control over resources and gender norms prevailing in the community.

At the household level

How does gender influence access to formal health care?	Household
How activities of women influence access to formal health care?	Women are expected to take care of the children, old and sick members in household hence lack of time. Employed women have dual duty of outside work and housework and hence pressed of time to take care of her health.
How does relative bargaining power influence access to formal health care?	Women with paid employment would have better bargaining power (10). Ritual status of women in the household influences her bargaining power (10).
How does access to and control of resources influence access to formal health care?	Usually women and even women in paid employment don't have access to and control over resources coercing them to resort to cheaper and inferior quality health care (11). Actually having control over resources would give women better bargaining power and Decision making status thus not only improve her health but also health of the entire household.
How do gender norms affect access to health care?	Women are not expected to go out (out of home and out of town) alone or without being accompanied by a man. Son preference leads to low priority to women's health hence the health of girl child in the household is neglected

At the community level

How does gender influence access to formal health care?	Community
How does environment influence the access to formal health care?	Remote and difficult area with long distance from the health care center combined with the inability to go out alone coerces a woman to resort to home remedies or traditional health provider.
How does relative bargaining power influence access to formal health care?	Due to lesser bargaining power of women in the community women's group are unable to attract micro financing (also due to under representation of women in committees) to form societies that can cushion the cost of health care and also make health care available in the community. Women belonging to the lower caste in a rural community cannot access health care services situated near upper caste settlement
How does access to and control of resources influence access to formal health care?	Most times the community resources are controlled and decision are taken by men. E.g. men decide to use funds to build a meeting house, not to build or donate an accessible land to build sub-center (health center) or a well that would save a lot of trouble to women
How does gender norms affect access to formal health care?	Cultural beliefs make women perceive their own needs for health care secondary to the men. Stigmatising diseases are perceived different for men and women. Most diseases have more stigmas for women than men.

Available health services

How does gender influence access to formal health care?	Available health services
How do activities of women influence the access to formal health care?	The timing of most health centers is in the morning when the women are busy in their daily chores.
How does access to and control of resources influence access to formal health care?	Only reproductive health is given importance in public health systems at primary care level and women ends up using the services of a traditional healer or sometimes quacks because she is unable to pay for the other private medical services (11).
How does gender norms affect access to formal health care?	Consent of man is need for a woman to access MTP services or for that matter even contraception. Women are not supposed to show their body parts to a male doctor. Women might not express her real complains, especially of private parts and disease with stigma.

Summary of needs identified using the above analysis

Timing of health centers to be client oriented and not provider oriented.

Availability of services near the residence (at least 5 km).

To provide comprehensive health care at primary care level.

Gender sensitive training to health care providers at all levels.

To reduce the cost of health care for poor.

Increase awareness and knowledge about the women's health and clear the misconception in the community (both men and women).

Micro financing system for women so that gives them some control over resources.

Women's group or self help groups to be encouraged to have self-employment for the women in the community.

Discussion

Socio-economic status combined with lack of access and control over resource plays a major role in accessing formal health care for women (11); hence we need a mechanism in the community to help women help themselves. In fact lots of committed NGOs are working closely with the community in poverty alleviation and rural development with specific interest in empowerment of women (12). Committed organization could also be used by the government to create awareness among community and implement programmes that otherwise could not be executed.

The policy maker have to recognize the gender dimensions of ill-health and response to ill-health for making and implementing pol-

icies and programmes to be really effective. They also need to sensitize the health care providers and the communities towards gender dimensions. More women at the policy making level could come out with policies and programmes that are gender sensitive but lack of time, due to their activities at home leaves her with less opportunity to access information and create self-awareness and women are neither encouraged nor supported to participate in politics or administrative services as governance is considered to be a man's job. Even with the 73rd and 74th amendment reserving seats for women in panchayants, they are merely a puppet in hands of powerful men (13) and leaves with very few women in power who can make decisions hence women are grossly under represented at policymaking level.

We also need to have a good health information management system with sex-disaggregated data that would give empirical evidence for the status of women's health and enable the policy makers to identify the problems and make gender sensitive policies that can be implemented.

Conclusion.

Government also needs to make health system reforms look carefully into the aspect of financing mechanisms of health care to poor, regulatory mechanism, information management, resource allocations. These reforms have to be gender sensitive. To have health planning and programme that are sensitive to women's need we need more women representatives at the policy making level and all policy maker need to be gender sensitive on the decisions they make. To have policies that are gender sensitive we need to have good database (sex disaggregated database) and health information management system. To implement these policies

Government has to look into the credibility of NGO's in the community and has to play an anchor role in involving (not complete transfer of responsibilities to NGO's). there is also imperative need for coordinating different government sector and NGO's working in different settings and sector to formulate and implement policies that would alleviate poverty and provide better health to all.

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