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GENDER HEALTH POLICY: AN AGENDA FOR GENDER EQUALITY AND SOCIO-ECONOMIC DEVELOPMENT IN INDIA.

Sociology

Dr. Oinam Shantibala Devi

Assistant Professor, Department of Sociology, Moreh College, Moreh, Manipur.

ABSTRACT

The paper deals with gender health policy and its impact on gender equality and socio-economic development of India. Health policy might address and promote gender equity. Gender equity and gender equality are terms that are sometimes used differently in different countries and in different contexts, and there is some disagreement as to which term is most appropriate. "Gender equality means the absence of discrimination on the basis of a person's sex in opportunities, allocation of resources or benefits, and access to services." In terms of health, these definitions are important. Health inequalities between women and men will reflect both biological factors, which are fixed, and gender differences, which are socially constructed and which are open to change. Thus, in terms of health policy the goal is often described as one of gender equity not gender equality. For example, policy should not aim to produce equal levels of mortality or morbidity among men and women, as some of the differences that exist reflect biological influences on health. However, it is difficult, if not impossible, to know what percentage of the health gap between women and men can be attributed to biology and what to gender. For example, research suggests that women's biology – particularly genetic factors – renders them more susceptible than men to tobacco-related disease, while gender differences in smoking behaviour also play a part. Gender equity in relation to health is not intended to produce equal outcomes for men and women, but instead must address inequalities between women and men in terms of their resources. Methodology: focus group discussion and interview with key population like health workers, officials and community leaders, literature review, used of published and unpublished materials related to the present issues. In order to collect empirical data the study used both primary and secondary sources of data etc.

1. OBJECTIVES OF THE STUDY:

I) To explore the correlation between health policy, gender equality, and socio-economic development of India;

ii) To analyse the necessity of health policy in the gender equality and overall socio-economic development of the country.

2. RESEARCH METHODOLOGY: Focus group discussion with policy officials, interview with key population like health workers, officials and community leaders, literature review, used of published and unpublished materials related to the present issues, collection of primary and secondary sources of data etc.

KEYWORDS

Gender Health Policy, socio-economic development, gender equality etc.

3. INTRODUCTION:

This paper focuses on the ways in which health policy might address and promote gender equity. Gender equity and gender equality are terms that are sometimes used differently in different countries and in different contexts, and there is some disagreement as to which term is most appropriate. However, in this policy brief we follow the definition of these terms as used in the Madrid Statement on gender mainstreaming in health policy in Europe. Gender equity means fairness and justice in the distribution of benefits, power, resources and responsibilities between women and men. The concept recognizes that women and men have different needs, power and access to resources, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes. Gender equality means the absence of discrimination on the basis of a person's sex in opportunities, allocation of resources or benefits, and access to services. In terms of health, these definitions are important. Health inequalities between women and men will reflect both biological factors, which are fixed, and gender differences, which are socially constructed and which are open to change. Thus, in terms of health policy the goal is often described as one of gender equity not gender equality. For example, policy should not aim to produce equal levels of mortality or morbidity among men and women, as some of the differences that exist reflect biological influences on health. However, it is difficult, if not impossible, to know what percentage of the health gap between women and men can be attributed to biology and what to gender. For example, research suggests that women's biology – particularly genetic factors – renders them more susceptible than men to tobacco-related disease, while gender differences in smoking behaviour also play a part. Gender equity in relation to health is not intended to produce equal outcomes for men and women, but instead must address inequalities between women and men in terms of their resources and their opportunities for health, including differences in how well health systems meet their specific needs. In this policy brief, the term 'gender equity' is used in relation to situations in which women and men have different needs that require recognition in health policy? 'Gender equality' is used in relation to descriptive material concerning health differences and also when describing country-specific actions.

Health systems across the world vary in the extent to which they have recognized gender equity as an issue, and in the ways in which they have framed the question and implemented change. It is not possible in a short brief of this kind to detail the approaches used in each country of the world. Instead, a short overview of the different ways in which gender has been addressed, both in Europe and in other parts of the world, is provided. Sections below refer to various studies and expert commentaries in making the case for various approaches. There are few syntheses based on research evidence in this field, and it should also be noted that some approaches are relatively new and so it may be some time before evaluations of their impact are available. The studies referred to in this report are selected to provide illustrations of the way in which an approach might be used and the potential benefits and costs, from European sites wherever possible. It is also important to note that these strategies overlap and that countries have pursued different combinations of approaches. For example, the decision to adopt gender budgets leads to a need for high-quality, regular and appropriate Gender disaggregated data, while gendered targets or benchmarks may also demand the development of specific outcome measures or indicators. Given the complexity of the various approaches that have been used in gender mainstreaming and in addressing gender equality and gender equity, it is helpful to divide the different strategies according to their primary focus. This permits the exploration of strategies focused on regulatory and legislative arrangements, those focused on organizational options and those that focus on information.

4. LITERATURE REVIEW:

Global Gender Gap Report 2007, provide insights into the gap between women and men in relation to specific indicators representative of gender equality. On the basis of indicators, including economic participation, representation in the public sphere, and education, countries are ranked by their gender gap. In 2007, for example, Sweden came top among European countries, having an equality score of 0.815, whereas Turkey came last, with a score of 0.577. The World Economic Forum's calculation of the gender gap includes two indicators relating to male/female health differences: the sex ratio at birth and the female/male ratio in healthy life expectancy (based on the estimated number of years lived in good health, taking into account the impact of disease, violence, malnutrition and other factors). Thirty-five countries worldwide share equal first place for the narrowest gap between men and women on this composite health indicator. These countries are diverse in terms of their overall health achievement: Angola and Yemen score well in terms of gender equality in health

alongside Austria and France, where the healthy life expectancies are higher. This suggests that while an approach that combines a number of indicators is a valuable tool at global level, particularly in the political realm, it may be more helpful to focus on detailed and health-specific indicators within and between European countries.

Gender-sensitive indicators help to provide solid evidence for the development of a gender-sensitive policy and also supply evidence regarding changes in health outcomes for both men and women. They can be used in different contexts and in countries with different health systems, thus permitting cross national comparisons of the gender gap in health.

Health surveillance data are currently widely used in a number of European countries to support health planning, the implementation of policy and the evaluation of the success of different services and strategies. For example, the European Community Health Indicators project developed four categories of indicators: three referred to social and other determinants of health, while the fourth referred to health outcomes. Assessment, and consideration, of the role of gender-sensitive indicators in health surveillance data already in use further strengthens the value of this approach. In many cases, new indicators will not be necessary, but existing indicators need to be evaluated. For example, are they gender-disaggregated, how sensitive are they for gender purposes and are they capable of reflecting gender differences in changes to outcomes following interventions.

Gender-sensitive health indicators and gender-disaggregated data may be particularly important in health-sector reform, as changes can have unintended consequences for gender equity which need to be explicitly addressed. For example, the introduction of, or changes to, user fees can impact differently on women and men because of women's greater financial insecurity, while changes designed to reduce lengths of hospital stay are also likely to adversely affect women more than men because of gender differences concerning responsibilities for unpaid care in the home.

5. REGULATORY ARRANGEMENTS AND LEGISLATION:

Gender equality legislation has been enacted in a number of countries in the world following international initiatives such as the United Nations Convention on the Elimination of All Forms of Discrimination against Women. However, the value of this legislation varies both in terms of content or cover and also how strictly the laws are enforced. Many countries have human rights and anti-discrimination laws, but these are limited in that they give individuals protection from discrimination rather than actively requiring organizations to promote equality. Gender equality legislation has also tended to focus on women's and men's participation in the public sphere – political representation, membership of legislative and other bodies, education and employment rights, including pay – rather than equity in terms of access to, and appropriateness of, health care services and health systems. A smaller number of countries in Europe have further developed antidiscrimination and equality legislation by requiring public bodies, including those in the health sector, to counter discrimination actively and to promote gender equality. For example, the 2006 Equality Act passed in the United Kingdom and the Norwegian Gender Equality Act of 2002 both included a duty for all public authorities to promote gender equality. These legislative changes led to the use of a variety of measures, including gender budgeting and gender impact assessments, at regional, national and local levels across a range of public-sector activities.

In addition, in health systems, legislation concerning the rights of patients can be used to promote gender equality. Since the 'Declaration on the Promotion of Patients' Rights in different countries have introduced patients' charters or laws on patients' rights. These approaches offer patients an opportunity to challenge health systems on legal grounds, that is, in terms of the denial of their rights as patients because of gender-based discrimination. Such approaches have their limits, however, including a lack of knowledge among patients, reluctance to make such challenges and a lack of knowledge among health professionals as well as policy-makers.

6. ORGANIZATIONAL APPROACHES:

There are a number of organizational options that can be developed to address gender issues, including gender mainstreaming, gender budgeting, gender impact assessment, targets for health outcomes and gender tools.

I) Gender mainstreaming:

Gender mainstreaming aims to address gender explicitly in policy, through a systems approach that integrates gender analysis and gender impact assessment at every level of policy. Such approaches have been important in development policy and in international organizations such as WHO, the United Nations and the European Union, but, worldwide, they have less often been introduced at country level.

ii) Gender budgeting:

Gender budgeting refers to gender-based analysis of various stages of the budgetary process and is often set in the context of human rights and legislative changes. Gender budgeting alone is not sufficient to bring gender equity, but should be part of a wider strategy in terms of gender mainstreaming, including, for example, gender impact assessment.

iii) Gender impact assessment:

Gender impact assessment was pioneered in the Netherlands and has been used in a number of other European countries. It has been defined as "the reorganisation, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies at all levels and at all stages, by the actors normally involved in policy-making".

The process was seen as being underpinned by three elements:

structures – referring to the identification of the most significant institutions and organizations in terms of gender inequalities; processes – an understanding of the mechanisms by which gender relations are constituted and reproduced; and criteria – meaning the ways in which interventions and outcomes were to be evaluated.

iv) Gender-specific targets:

Gender-specific targets are another option for organizational approaches. They are promoted as part of the 'European Health for All' strategy of the WHO Regional Office in the different office of the world. The targets are focused on outcomes rather than inputs and create an environment in which health systems are required to deliver specific results. Targets or benchmarks can be set at international level, as exemplified by the Millennium Development Goals. To be successful, targets need to be 'owned', measurable, involve stakeholders and include management incentives. Health targets are used increasingly within countries, at various levels of health policy, and set a commitment for specific outcomes in a specific time frame. They may focus on issues relating to perceived quality of care, such as patient satisfaction, or health outcomes, including reductions in disease-specific mortality rates, for example. Targets can be set at national, regional or local level, or all three, as they are devolved through health systems. In England, for example, national targets for mortality reduction are set as part of government expenditure plans; there are specific goals for individual ministries (including that for health) and for the dates by which these goals should be achieved. These are incorporated into Public Service Agreements, and departmental funding is linked, in part, to these targets.

Health-system targets have, in the main, not been gender-specific. However, it is possible to include 'gender dimensions' based on evidence of health differences between women and men. For example, targets in relation to use of health care might have specific goals for men and women to reflect current patterns. Screening programmes (such as those for bowel cancer that are currently being either piloted or introduced in a number of European countries) might aim for gender-specific increases in annual uptake, in response to the currently low uptake among men, rather than adopting a global target. It should be noted that there is little rigorous evidence demonstrating the success of health targets or indicating long-term gains. It is also possible that targets might distort outcomes where they encourage the switching of resources to one objective at the expense of others that have not been identified as targets. Thus, the use of health targets in a gender-specific way needs to be accompanied by robust evaluation of the consequences for men and women, and also analysis of any emerging unintended consequences where such targeting has encouraged a shift in focus or resources.

v) Informational approaches:

Good information is an essential part of health stewardship and the promotion of health equity, and the approaches outlined above all call for gender disaggregated information. The third approach for gender equity used to varying degrees in European countries relates to the

provision and use of such information. There is a need for gender-disaggregated data in all health systems. These data need to be routinely available across the health system; they need to be comprehensive and readily accessible. Unfortunately, these requirements are still not being met in a number of European countries. In addition, there is a need for what are sometimes described as 'gender-sensitive health indicators' and for public reporting of the gender gap. Indices of gender equality and gender equity are also valuable: they are compiled from data from a range of sources, including censuses, sample surveys and nationally collected statistics, in order to 'give shape' to gender-disaggregated data.

6. CONCLUSIONS:

The gender equality duty filters down throughout the health system in India. So, those involved in delivering health care at the local level are also required to draw up and publish a gender equality scheme and evaluate their performance. This involves asking questions about whether men and women have different issues in relation to health care, different requirements and whether their needs are likely to be met appropriately by existing services. Health organizations also have to conduct gender impact assessments of new policies, strategies and interventions. One of the main advantages of this kind of regulatory approach is that it is proactive rather than reactive, in that public-sector bodies are required to address gender. In health systems, where it may be less easy for individuals to prove discrimination than in employment, for example, this is important. This approach also has the effect of mainstreaming gender: the subject has to be considered in everything that an organization does. It places gender equality in a central position in policy-making and right through to the delivery of care. It is also possible to make gender part of a wider equalities agenda; this, in turn, enables those implementing different strategies to learn from each other and from examples of good practice across the spectrum. When such a duty is introduced, there is a need for good evaluation and dissemination over a long period prior to the legislation becoming live, and afterwards. Costs are likely to be high, partly because of the resources needed for dissemination, but also because of the need for training, support and enforcement. There can be confusion within organizations as to whether they are included and also how such a duty might impact on their work in the initial phase, for example, causing anxiety regarding the legality of providing services that are only for women or only for men. There are also resource implications arising from the need for regular evaluation of gender equality schemes and also from the need for monitoring, and enforcement, of the law. One of the main barriers to pursuing this approach is that it is based on national legislation and is therefore difficult to introduce, requires political will and 'champions', and takes time to become effective.

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