

Journal of Kolkata Society for Asian Studies: Vol 10. Special Issue II, December 2024

Gender Equity and Health: Examining Health Policies for Women in India

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Abstract

Addressing the issue of health and more importantly, women's health is largely dependent on societal and environmental factors. Interventions for women's health difficulties are necessary at every stage of their lives. The essay examines the distinction between gender equity and equality and how women's health has been addressed globally. By looking at secondary data on demographics, marriage and fertility patterns, sanitation, and nutritional status the study seeks to understand the Indian women's health status. Additionally, the study examines the different health policies that have recently been created to address women's health requirements. It concludes thereon that health issues of women are not an isolated issue and are intrinsically linked to education, employment opportunities, and participation in the decision-making process.

Keywords: *Health, Gender Equity, patriarchy, nutrition, sanitation, hygiene, health policies*

1. Introduction

The health of an individual is one of the basic human rights that indicates the individual's well-being. In addition, the development of women's health as a human resource is an important factor in the progress and overall advancement of any country. India has throughout time reinforced and restructured its primary healthcare implementation system as a signatory to the Alma-Ata Declaration. The National Health Policies have also emphasized 'Health for All' and at the same time aimed for Universal Health Coverage (UHC).

The health of an individual is a complex phenomenon that depends on social and environmental factors. As a result, the health of Indian women is inseparable from the discrimination that exists in Indian society and spreads to the household. Women in Indian society are treated in a qualitatively inferior manner as a result of patriarchal rules and values. Furthermore, the lived experience of women's health in India, a large and sociocultural diverse nation, differs with social stratification like caste and class, as well as with rural-urban dichotomy and regional disparities. (Misra, 2006). The androcentric view used to address health issues harms women's health. Gender discrimination at the societal level has led to unequal representation of women in health policies. Health policies about women in India

have been a neglected area in policy research primarily focussing on maternal health programmes. While these kinds of treatments are essential for maintaining the health of both mother and child, health policy makers must address gender issues as women go through different stages of life.

Based on certain factors interacting between gender and health, such as demographic position, marriage and fertility profile, sanitation and nutritional status, and health policies created to address the issue of gender inequity in health, this paper delves into women's health in India as a human right.

2. Material and Methods

The study utilized data from National Family Health Survey (NFHS) 5 which was conducted in 2019-2021. The NFHS-5 is a thorough, cross-sectional survey that collects data at the state/UT and national levels and provides estimates on key indicators on demographics, health, nutrition and gender equality. Information about the sample size, sampling strategy, and data quality can be found in the NFHS reports. Data for the NFHS-5 came from a total of 6,36,699 homes. In addition to NFHS 5, a literature study is used to accomplish the objective of this work. Searches on Social Policy and Research, Pub Med, Hinari, Med Ind, and Google Scholar were done to obtain review literature on gender disparities in health.

Review of Literature

The discussion on gender equity in health arises from the fact that women's health requirements are different owing to the epidemiological contour of the sexes. Hence gender is a significant indicator of the inequality in health in most developing countries. To analyse the gender aspect in health the study heavily draws from literature relating to two aspects. Firstly, how is gender related to health and the conceptual understanding of gender equity, and secondly women's health needs like nutrition, sanitation, and hygiene and how they have been addressed in India.

Extant studies have focussed on bringing about the conceptual understanding of gender equity specifically concerning health (Mooney, 1987; Kutzin, 1995; Sen and Ostlin, 2008; Payne, 2009; Sen and Iyer, 2012; Heise et al., 2019; Weber et al., 2019; Heymann et al., 2019). Gender equity in health is measured with its relation to access to health and health outcomes. Access to health has shown that healthcare has been underutilized by women owing to expenditures that have significantly affected health outcomes (Saikia and Bora, 2016; Bhan, 2016; Chidambaram, 2018; Das et al., 2018; RaoGupta et al., 2019; Mondol and Dubey, 2020). Discussions on how limited decision-making independence and access to financial resources have adversely affected women's health have also been documented in several studies (Santow, 1995; Bloom et al., 2001; Batra, Gupta and Mukhopadhyaya, 2014; Saikia et al., 2016; Mohan et al., 2019). Numerous investigations have also documented that women's health is adversely affected due to nutritional deficiency which in turn affects maternal and child health (Mishra, 2006; Sinha et al., 2017; Narayanan et al., 2017, 2019;

Vir and Malik, 2015; Nanda et al., 2015). Sanitation and menstrual hygiene are other problems faced by teenager girls in poor nations which have a direct effect on their health. Studies related to sanitation show that open defecation leads to poor health in women and also affects their mental well-being and security (**Pardeshi 2009; Nallari 2009; Majumdar 2010; Padhi et al., 2015; Saleem 2019**). Studies related to menstruation hygiene have discussed women's experience in managing menstruation and the effects of poor menstrual hygiene (**Lahiri-Dutt, 2015; Koonan, 2019; Majeed et. al., 2022; Vogel et al., 2022; Karjee et al., 2023**).

The vast literature on gender equity and health has addressed multiple women's health problems from physical to mental which can be improved with policy initiatives that aim at women's empowerment.

Gender Equity and Health

Health inequities have been identified across the globe as a major concern which has a separate dimension when interlaced with gender and poverty. The WHO Commission on Social Determinants of Health posits that gender-based health disparities stem from political, social, economic, and environmental factors, rather than solely being attributed to limited access to healthcare (**World Health Organization, 2008**). The subordinate socio-economic position of women to men has led to poor health outcomes amongst women which include anemia and nutritional deficiencies, HIV/AIDS, and several other sexually transmitted diseases and maternal mortality and morbidity (**Heise et al., 2019; Weber et al., 2019**). To address gender-related health inequities, there is a growing understanding that the variables influencing men's and women's health are as distinct as their biological makeup. Gender discriminations are socially constructed and subject to change, while biological causes determine health disparities between men and women. The connection between gender and health should be studied in light of women's particular health requirements and take into account the variations in the epidemiological profiles of the sexes. Due to the biology of reproduction, it is necessary to investigate the specific health needs of women. Despite their widespread use, the Madrid Statement on Gender Mainstreaming in European Health Policy defines gender equity and equality differently.

“Gender equity refers to the equitable and just allocation of benefits, power, resources, and responsibilities between individuals of different genders. The concept acknowledges the existence of distinct needs, power dynamics, and resource accessibility between women and men. It emphasizes the importance of identifying” and addressing these differences in order to correct the imbalance between the genders. However, "the absence of discrimination based on a person's sex in opportunities, allocation of resources or benefits, and access to services" is what gender equality means. These two definitions make it relevant for health policies to acknowledge the biological differences between men and women and, as a result, refrain from trying to achieve the same results with the same set of policies. Therefore, gender equity rather than gender equality is frequently the purpose of health

policy. However, it is challenging to determine how much of the health disparity is due to gender and how much to biology (**Payne, 2009**).

Aside from biological reasons, inequalities exist within health systems about access and utilization of health services, demonstrating power relations that make health a site of gender conflict. Because of their status in society, women are more vulnerable than men since they have fewer options to earn a living and access other resources like health care, which increases their dependence on other people for security and survival. The measure of equity in healthcare is related to the concept of access i.e. improving access to healthcare for those with the greatest needs and also to outcomes like health status or consumption of health goods. The gender approach to healthcare raises the question that improving access to healthcare is not a sufficient condition for achieving equity in terms of health status. It is important to pay attention to making scarce resources available that will be directly beneficial to women (**Standing, 1997**).

There are two approaches to show that there is gender inequality in health: gender disparities in health risks and gender disparities in healthcare. The historical legacy of gender inequality in society means that women, particularly impoverished women, bear a minimum share of the health-related costs of gender inequality. Men and women have different risk factors for illness, disease, and disability. Women are allocated domestic duties that require a lot of physical labour, such as gathering firewood or water for household use. (**World Health Organization, 2016**). According to a study, cooking with these solid fuels contaminates the air in the home. In low-income countries, household air pollution is one of the leading causes of death among women from noncommunicable diseases such as heart disease, lung cancer, and stroke (**World Health Organization, 2018**). Since women have historically found it difficult to afford healthcare, access to care is a prime example of significant gender disparities. Additionally, women have relatively little autonomy when it comes to making decisions about their own sexual and reproductive health, such as whether to use contraceptives or what medical treatment to get after giving birth. (**UN Annual Report, 2019**). Gender biases in health have a direct effect on maternal under-nutrition and impact the weight of babies (**Shah and Shah, 2010**) and malnutrition amongst children of both genders (**Sethuraman et.al., 2006; Bhutta et. al., 2008**).

Several international forums have “addressed the issue of gender inequality, with the Fourth World Conference on Women in 1995 being the first to address the topic of gender mainstreaming (**United Nations, 1996**). Gender mainstreaming refers to the process of assessing the effects of any planned action on men and women, such as laws, policies, or programmes. The goal is to ensure that men and women benefit equally and that inequality does not” persist. (**United Nations, 1997**). Its purpose is to include gender concerns in policies and programs to address the power disparity between men and women and enhance health outcomes in the medical field. (**World Health Organization, 2009**).

Emergence of Gender Equity on the Global Platform

The consideration of gender equity and its health implications have been addressed across several deliberations of WHO and the UN. Several of these reports highlight that gender equality plays a very prominent role in overall economic productivity. The UN's Decade for Women (1975-85) dedicated an entire decade where gender-related inequality in various sectors was highlighted. Throughout the 1990's women's right to education, health economy, and political participation was represented in various global forums.

A turning point for global health was reached in 2007 with the WHO's Commission on Social Determinants of Health, which proposed that social, political, and environmental factors—rather than healthcare access—are the primary causes of health disparities, with gender playing a significant role. The report also highlighted that the inherent patriarchal norms of society translated into negative health outcomes for women and girls (**World Health Organization, 2008**).

The “Gender Disparity Index (GII) was created by the United Nations Development Programme (UNDP) in 2008 to assess the effects of gender inequality on health. The GII is a composite index that assesses three facets of women's lives: involvement in the workforce, empowerment, and reproductive health. The percentage of women who complete intermediate education, the number of women entering the workforce, the representation of women in the legislature, and the rate of maternal and adolescent mortality are the five indicators that are used to calculate it (**UNDP, 2008**).

One of the most important aspects of the Sustainable Development Goals (SDG) of the United Nations is gender parity in health. It is acknowledged that achieving SDG Goal 5 on Women” Empowerment and Gender Equality is a prerequisite to achieving other SDGs. This entails putting a stop to discrimination and exploitation of women, acknowledging unpaid caregiving and domestic labour, guaranteeing access to reproductive rights and sexual health for all people, and granting access to intermediate technologies. (**Dhar, 2018**).

Looking at the concept of Gender Equity in health and how it is addressed at the global level, the next section delves into Indian women's health by examining the demographic position, marriage and fertility profile, sanitation and nutritional status, and the various health policies that have been designed to achieve the objective of Gender Equity.

3. Discussion on NFHS 5 DATA

Demographic Status of Women

Gender composition is an important criterion for analyzing the character of a given population. India's sex ratio is 1020 according to the NFHS-5 (2019–21), which puts the country in a better condition than it was in NFHS-4 (2015–16), which was 991. The states of Kerala (1084), Tamil Nadu (995), and Andhra Pradesh (992) have favourable sex ratios, while Haryana (877), Jammu and Kashmir (883), and Sikkim (889) have low sex ratios.

Even though the sex ratio in terms of population has advanced, the survey shows that the sex ratio at birth for children born in the last five years is 929, a slight improvement from the NFHS-4 which was 919.. Poor child sex ratio is a clear indicator of widespread sex-selective abortion and sex determination using diagnostic techniques like ultra-sonography in urban and semi-urban areas and gradually moving to rural areas. Amartya Sen has referred to the discrepancy in the male-to-female sex ratio as the "missing women" problem. **(Sen, 2002)**. Inequality and neglect at all stages of women's lives are the cause of relatively higher female mortality than men in many developing countries.

Marriage and Fertility Profile

According to NFHS-5, the percentage of women between the ages of 20 and 24 who marry before turning 18 has decreased from 26.7% in NFHS-4 of 2015–16 to 23.3% of the population. The progress made in this domain has been remarkable as there has been a remarkable decline in the percentage of women who got married before the age of legal age of 18 years. Even the number in rural areas (27%) in NFHS -5 is much less than the total percentage in NFHS-4 (31.5%). The Total Fertility Rate (TFR) that is children per woman has also seen a slight change from 2.2 in NFHS-4 to 2.0 in NFHS 5. However, although the age group of girls from 15-19 years who were pregnant or already had a child at the time of the survey has come down from 16 % in NFHS-3 to 7.9 % in NFHS-4 to 6.8 % in NFHS 5, the dominant form of contraception has been female sterilization which was 37.9% with male sterilization at 0.3 % in the survey of 2019-21(**IIPS 2021**).

Sanitation Related Needs for Women

Sanitation needs to be seen as a social issue and a human right to achieve gender fairness. Menstrual hygiene and open defecation are the two components of sanitation-related needs for women. Due to their unique biological makeup, women have particular requirements for cleanliness and hygiene that are related to the reproductive process. According to NFHS-5 rural and urban households that use sanitation facilities include 70.2 % which is even lower in rural areas which stands at 64.9%. Plausible evidence shows open defecation has adverse effects on maternal health. Pregnant women who defecate in the open have a higher chance of hookworm infestation than those who use toilets **(Majumdar et al., 2010)**. Open sanitation has also been a cause of stress and trauma for women at different stages of their lives. Extant studies show that girls have experienced trauma while finding an open place to defecate, fear of being watched while defecating, and restricting their defecation or urination **(Hirve et al., 2015; Sahoo et al., 2015)**.

For women, Menstrual Hygiene Management (MHM) is another significant sanitation-linked issue. Menstrual health has gained attention on a global scale in recent years, with particular attention paid to women's lived experiences in low-income nations about access to sanitary products, clean water, and toilets **(Critchley et al., 2020)**. Research indicates that of the 113 million teenage females in India, approximately 68 million attend 1.4 million schools. One factor that discourages adolescent

girls from attending school is poor menstrual hygiene practices (**Thakur et al., 2014; Muralidharan et al., 2015**). Studies show that lack of cleanliness during menstruation leads to morbidity and other problems like abdominal pain, urinary tract infection, and pregnancy complications (**Swaminathan, 1987; Ramachandran et al., 2016**). Like other health issues, a woman's menstrual hygiene is also influenced by her socioeconomic position. Gender disparity has resulted from men's ignorance of menstruation hygiene and the social restrictions and lack of education placed on girls (**Mason et al., 2017**). The study also shows, 'women and girls experience stress and trauma when there are insufficient sanitary facilities to manage menstruation' (**Sahoo et al., 2015**).

Gender parity is a bigger goal when it comes to sanitation measures, and in India, women's sanitation and hygiene have traditionally been seen as infrastructure problems. Infrastructure is important, but there are also structural issues that must be addressed since they lead to stress and trauma and are dictated by unequal gender standards.

Nutritional Status of Women

In poor and low-income countries nutritional deficiency is common amongst people and women in particular. Conversely, the child's dietary needs are greatly influenced by the mother's health. There is evidence that women's nutrition affects the health of their children and this is the reason why health policies should put a lot of emphasis on women's nutrition (**Mason et. al., 2012**) Women require greater attention to nutrition owing to the natural processes of menstruation and child birth. However, in India, the nutrition of women is heavily guided by social norms and practices. These include eating last and taking less, giving up on food when food is less to ensure that the husband, children, or their in-laws have enough. These social customs are not adjusted even during the crucial events of women's life like pregnancy and breast-feeding when more nutrients are required. In some communities, pregnant women are encouraged to eat less to have easier deliveries or fast for their sons which deprives them of essential nutrients like protein and iron and also reduces calorie intake (**Narayanan et. al., 2019**). Study shows in Punjab even with agricultural growth and economic development social discrimination against young girls in nutritional matters continued to persist. In matters of women's child care and feeding practices gender disparity persists where the girl child is breastfed less frequently and for shorter durations than the boy child (**Chatterjee and Lambert, 1989**).

National data collected from NFHS-5 show 18.7% of women with below normal Body Mass Index (BMI) which indicates nutritional deficiency among women. The prevalence rate of undernutrition was higher in rural areas (21.2 %) compared to urban areas (13.2%). Adults' BMI serves as a gauge of their nutritional status. BMI of less than 18.5 among adults leads to low productivity and reduced immunity to illness while overweight leads to the development of other types of health problems. There have been significant changes in BMI of women with improvement in maternal health services when compared with the NFHS-4 (22.9) and NFHS -3 (35.5)

According to the national data, the prevalence of anaemia amongst women was also high. During pregnancy the requirement of iron increases but it is not fulfilled by most Indian women. NFHS-5 presents women between the ages of 15 and 49 for the survey. 57.2 % were anaemic while 53 % of pregnant women in the same age group were anaemic. For women with anemia, not getting enough energy, proteins, and fats is the main cause of this condition. The study conducted on women from Ten Indian States showed poor intake of various other nutrients required by girls during adolescence, before the onset of pregnancy, and during pregnancy (**NNMB, 2012**). While poor purchasing power is the primary cause of poor maternal nutrition other factors like early marriage, conception below 20 years of age, and poor knowledge of self-care contribute to inadequate maternal nutrition. Pregnancy-related poor nutrition raises the risk of low-birth-weight newborns which starts a genetically transmitted vicious cycle of stunting. Further, it results in short adults with tiny pelvic sizes, which increases delivery problems, mortality, and morbidity (**Vir and Malik, 2015**). Cultural practices and social norms have a powerful and direct impact on the food intake of women in the family. According to research, young women are the first to give up food to make sure that their husbands, children, and in-laws have enough to eat. Even when food is scarce during poor times it is women who cut down on nutrition to ensure that children and men have enough food. Such coping strategies lead to under-nutrition among women. Evidence from rural India shows, that a significant number of mothers whose children show improved nutritional status have shown a decline in BMI in the same period (**Narayanan et. al., 2019**).

To effectively address the nutritional aspect of women's health, policy initiatives need to identify the specific barriers that hinder women's "nutritional empowerment." Nutritional empowerment refers to the process through which women acquire the capacity to attain good health in an environment where they were previously deprived of this capability. It covers information on food consumption in addition to social and economic resources. (**Narayanan et. al., 2019**).

Programmes for Achieving Gender Equity in Health in India

To address gender equity in health several efforts have been initiated by the government encompassing all spheres of women's health. The flagship empowerment programme to protect the girl child is the Beti Bachao Beti Padhao (BBBP), which ensures her survival, education, and safety and identifies the creation of a conducive socio cultural, economic and political environment to enable women to enjoy their rights. According to NITI Aayog's discussion on poverty, women's health has also been positively impacted through Ujjawala Yojana (cooking fuel distribution) and Saubhagya (improved electricity coverage) which has escalated their living conditions and this has significantly contributed to bringing down poverty as 24.82 crore people escaped multidimensional poverty in the last nine years.

Menstrual health is a major public health concern in India, yet it went largely neglected by

government, until the early 2000s. Between 2005 and 2010 policy makers have made considerable strides toward improving Menstrual Health and Hygiene (MHH) for women and girls by incorporating it in National Rural Health Mission (NRHM). In 2011, the Scheme for Promotion of Menstrual Hygiene among adolescent girls in the age group of 10-19 years was adopted by Ministry of Health and Family Welfare. Under this scheme, Accredited Social Health Activist (ASHA) provides sanitary napkins to adolescent girls. Under the Pradhan Mantri Bharatiya Janausadhi Pariyojna (PMBJP), health security for women is ensured through Janaushidhi Kendras that provide sanitary napkins that are oxo-biodegradable. In 2015 the Ministry of Drinking Water and Sanitation under Swaachh Bharat Abhiyan issued guidelines to raise awareness on Menstrual Hygiene Management (MHM) in rural areas as part of its mediations to change sanitation hygiene behaviour (PIB, 2022). International efforts such as “UNICEF’s WASH” (Water, Sanitation and Hygiene) program have contributed to addressing the infrastructure needs related to sanitation.

Apart from menstrual hygiene, sanitation policy has also evolved over the years. In 2008, one of the main focus areas for National Urban Sanitation Policy was to improve the hygienic conditions of women through cost effective technologies. The Swaachh Bharat Mission-Grameen addresses issues related to safety, privacy and dignity of sanitation related needs of women in public places. Innovations in women friendly sanitation include Sthree Toilet in Karnataka as a mark of gender sensitive sanitation infrastructure. Pink Toilets in Noida is specifically designed to address the emergency needs of women for convenience, security and privacy (PIB, 2024).

In 2018, the National Nutrition Mission (NNM), also known as POSHAN Abhiyaan was inaugurated which aimed at improving nutritional outcomes for children, breastfeeding mothers, and pregnant women. In order to realize its goal, the Mission integrates with maternal health platform like Pradhan Mantri Matri Vandana Yojana where cash incentive is provided to pregnant and lactating mothers to bring about improvement in maternal health. Another element of POSHAN Abhiyan is Anaemia Mukh Bharat which provides folic acid and prophylactic iron supplementation (PIB, 2023).

In order to deal with the issues of lower male sterilization which is rooted in patriarchal bias of the society, Mission Parivar Vikas was introduced in 2016 under National Health Mission for improving access to contraceptives and family planning services across 145 high fertility districts of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Chhattisgarh, Assam, Jharkhand. The increased prevalence of unwanted pregnancies is the result of absence of counselling of women on birth spacing and alternative ways of contraception. The Mission aims to empower women to make their choices and also involve men in the process (PIB, 2019).

4. Conclusion

The gender perspective is crucial in health interventions due to the influence of gender on health in India. Apart from the health programmes aimed at improving women’s health, policy documents

have also recognized the need for a holistic approach to address gender equity in health. The National Policy for Women 2016 (Draft) recognizes the need to provide 'holistic and life cycle approach to women's health for appropriate, affordable and quality health care'. The policy documents emphasizes on the need to address nutritional deficiencies in all stages of their life and the need to put an end to intra-household discrimination against women and girls when it comes to nutrition **(GoI, 2016)**. The document recognizes sanitation and drinking water as more of a social issue and important for women's health. Educating women about hygienic practices and involving them in decision making process in waste disposal and improving water and sanitation systems has been discussed in the document. The National Health Policy 2017 also aims to look after the health requirements of women beyond the reproductive age group of forty years. The policy document also speaks of strengthening public hospitals making them 'more women friendly' **(NHP, 2017)**. Since 2005, the Indian Union Budget has included a gender budget. By allocating funds to activities and initiatives geared towards women, gender-responsive budgeting effectively addresses gender inequality and closes the gender gap in all spheres of social, economic, and political life. Gender Budgeting has also been recognized in The National Policy for Women 2016 (Draft) which calls 'for gender focal points, gender desks, Gender Budgeting Cells set up in Ministries, state government Departments, Panchayats and urban local bodies' **(GoI, 2016)**. Another successful strategy for public health initiatives is community participation. Research indicates that community-based health interventions have reduced malnourishment among young women and girls in the community and assisted them in forming good personal habits **(Pradhan et al., 2023)**. Research has shown that combining community-based health intervention initiatives with self-help groups increases women's empowerment. Women's empowerment, on the other hand, plays a critical role in influencing healthcare choices and women's physical and mental well-being. **(Roy and Chaudhuri 2008; Sahu and Singh, 2012)**.

Despite health interventions, the statistical health profile of women in India shows that the implementation of policies and programs on women's health in India has lacked a holistic approach that links women's right to health with other rights in the establishment of an egalitarian democratic society. As in other places, gender disparity in health is still a problem in India. Gender equity is measured with the GGGI. The four components that make up the Global Gender Gap Index (GGGI) are economic participation and opportunity, educational achievement, health and survival, and political empowerment. India had a score of 0.944 in the GGGI Report 2020 for health and survival. Understanding how rights in other areas, such as protection from violence, employment opportunities, political participation, and access to education, fit into the larger framework of the right to equality and nondiscrimination is crucial for achieving gender equity in health. Reducing health disparities and advancing women's rights to health can be achieved by tailoring health policy to account for these socio-economic considerations.

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