MODULE 33. GENDER IN HEALTH POLICIES

1A. Personal Details

Role	Name	Affiliation
Principal investigator	Prof. Sumita Parmar	Allahabad University, Allahabad
Paper Coordinator	Dr. B Subha Sri	Rural Women's Social Education Centre, Tamil Nadu
Content Writer	Prof T K Sundari Ravindran	Professor, Achuta Menon Centre for Health Science Studies, Trivandrum
Content Reviewer (CR)	Dr B Subha Sri	Rural Women's Social Education Centre, Tamil Nadu
Language Editor (LE)		

2B. Description of the Module

Item	Description of the Module
Subject Name	Womenôs Studies
Paper Name	Women and Health
Module Name/Title	Gender in health policies
Module I.D.	Paper-8, Module33
Objectives	To make the reader understand processes of policy making, gender analysis of policies and gender mainstreaming policies
Keywords	Gender, Gender analysis, Health policy

1. Introduction

Ensuring that health programmes recognise and address the specific health and health care concerns of women and men requires changes in policy, including the law and changes in practice. The purpose of this module is to provide a basic introduction to what constitute gender equitable health policies, and approaches to making health policies gender equitable.

1.1 What is policy?

Policy is defined as ña plan or course of action, as of a government, a political party or business, intended to determine decisions, actions and other mattersò (1).

Although ópolicyô is generally understood to mean legislation or rule made by governments, policies exist beyond these, at all levels of societies, ranging from international organisations to communities and households. Policies also exist within different sectors of society, including the private sector, civil society actors and religious and social institutions.

In this module on gender and health policies, we are concerned specifically with public policy, or policy made by governments at various levels. Government policies are not always written down as policy documents. They are often issued as government orders, as departmental orders and regulations within specific government departments, and sometimes, as statements of intent by heads of governments and senior government functionaries. Policy can also be made through legal court cases, and through regulations such as government decisions about acceptability of a specific drug.

It is important to acknowledge that policies are not always implemented as intended. The ópolicy-in-practiceômay be very different from the policy-on-paper. This may be unintentional and caused by practical difficulties in implementation, or deliberate, resulting from opposition by one or more groups of stakeholders responsible the implementing the policy.

Sometimes the non-existence of a policy on a specific issue of importance is in itself a policy to maintain the status-quo. For example, if there is no legislation or regulation to ensure access to health services for low-income groups when cutting down expenditure on health, this means that irrespective of the content of written policy, the de-facto policy discriminates against low-income groups.

Health policy, which this module is concerned with, is any policy which includes actions undertaken with the aim of maintaining or improving a populationôs health, and/or providing for the care, treatment or cure of ill health may be considered as a *health policy (2).* Thus, tobacco control policies, policies for improving access to food through food subsidies, or controlling environmental pollution may all be considered health policies. Health care policies or health services policies, which are about the organization and provision of health services are a subset of health policies.

1.2. The policy process

There are many different approaches to understanding the policy-making process . According to the órationalistôapproach to policy analysis, policy makers are rational individuals, with all necessary information at hand, who use this information to decide upon policy and then implement it. According to this approach, the first step in the policy process is ó***problem identification'*** when an issue is identified as a problem that needs to be addressed through policy measures. The second step is one of ó***solution development'*** when a range of potential solutions is developed and an appropriate policy is chosen. The third is the ***implementation*** stage. The fourth is the policy outcome stage, when the desired outcome is achieved. *(3,4).*

Grindle and Thomas (1990) developed a model, which illustrates a variation of the above approach. *(5)* According to their model each stage in the policy process involves complex decisions. The first phase is the óagendaôphase when a particular issue is considered for inclusion on the policy agenda. It is only when policy makers

are convinced that the issue is important that the policy-making process begins. The next is the decision phase, when policy makers decide whether or not anything will be done about the issue at a given point in time. Once there is decision in favour of a policy, an appropriate policy is formulated and implemented. The third phase is the implementation phase, and the policy may or may not be successfully implemented. The usefulness of this model lies in its alerting us to the possibility that the policy process can halt at any stage ï not only during formulation, but even during implementation. The model also indicates that the task is not complete once a policy has been enforced. Continuous efforts are needed to assess policy outcome. Further modifications to policy may be needed or more political support may need to be garnered to make sure that the policy successfully achieves the desired outcome *(5).*

These models help provide a basic understanding of the policy process. In practice, the policy process is much more complex. Policy makers are often subject to conflicting pressures and demands from different stakeholders, may have to act on inadequate of conflicting evidence, and may be engaged in struggles for power, whether through elections or within a bureaucracy. More often that not, it is such factors that determine whether or not an issue is on the agenda, and the nature of policies evolved to address the issue.

2. Gender-mainstreaming health policies

2.1. Approaches to women and gender in health policies

Approaches to women and gender issues in policies, including health policies have been classified in many different ways. The following is a modified version of a well-known schema for categorising how policies identify and address gender inequalities is that by Kabeer *(6).* According to this schema, policies may be classified as

- gender-unequal
- gender- blind
- gender- specific, and
- gender- transformative

Gender-unequal

Gender unequal policies actually grants greater privilege to menôs well-being than womenôs. These are policies which directly deny womenôs rights or give men rights and opportunities that women do not have. For example, a policy that requires a manôs consent before a woman can undergo an abortion is gender-unequal.

Gender- blind

Gender blind policy fails to take into account, or is ñblindò to gender differences in the allocation of roles and resources. Such policies are not intentionally discriminatory, but reinforce gender discrimination nevertheless. Thus what may appear to be a good policy ï for example shifting from institutional to home-based care for the mentally ill- may not impact equally on men and women since women patients may not have care-givers at home while men may be cared for by female members of the household.

Gender-specific

Gender specific policy is aware of the differences in womenôs and menôs needs roles and access to resources and tries to address them. However, it does not seek to change the power balance between women and men. For example, providing for women doctors to treat women patients because of strict sex segregation; or starting a reproductive health clinic for men.

Gender- transformative

Gender transformative policy tries to meet the health needs of women and men and at the same time, change the allocation of roles, resources, and power between men and women in society. For example: raising awareness amongst men on the reproductive health consequences of their reluctance to take responsibility for contraception; providing women with the financial means to access health services.

Gender mainstreaming

Another terminology often found in the policy literature is ñ*gender mainstreaming*ò. Mainstreaming gender has been defined as

> *"... a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between men and women is not perpetuated. The ultimate goal is to achieve gender equality". (7).*

Gender mainstreaming is about paying attention to gender differences and inequalities systematically in the design and implementation of all policies and programmes. This approach evolved to correct the tendency to have separate token interventions for women, while mainstream policies and programmes continued to ignore gender concerns.

The process of gender mainstreaming health policies implies the progressive move from a gender unequal or gender blind policy towards gender transformative policies. There is often a misconception is that when gender in ómainstreamedôthere will be no need for separate ówomen-onlyôprogrammes. This is not the case. Specific women-only programmes may be needed to off-set current inequalities, while simultaneously attempts are made to mainstream gender concerns into all new policies and interventions.

2.2. Mainstreaming gender within health policies

Limitations of population-wide approaches and approaches targeting the poor in general (8)

Health policies usually focus on households as a unit. Those that do address womenôs health needs focus on the specific health needs or additional health needs of women and girls because of biological differences between sexes and consequent differences in epidemiological profiles by sex. Reproductive health is a major, though not exclusive, focus. This approach is similar to the gender-specific approach discussed above.

In recent times many low and middle- income countries have introduced health policies specifically to protect the poor from the negative consequences of cuts in public expenditure on the health sector. Unfortunately these ópro-poorô policies are also often gender-blind.

For both women and men, health risks and vulnerabilities related to poverty include overwork, under-nutrition and hazardous living and working environments *(8)*. However, for women, these risk factors interact with those emerging from their role in biological reproduction as well as risks and problems related to gender-based roles, norms and inequalities. For example, within poor households, women may have less access to nutritious food than men. They also work longer hours and have less rest because of the burden of domestic work. In addition, they also bear children and breastfeed them. Because of poverty and inability to afford weaning foods, women may be forced to breastfeed for longer durations. The combination of these multiple factors can place women at greater risk of ill health than men.

The stresses of every day living, child bearing and rearing and catering to a householdôs needs under serious resource constraints contributes significantly to depression in women. Gender-based violence is another dimension of womenôs experience of ill health.

Not only are poor women at greater risk of ill health, they may not be able to seek appropriate health care promptly because of gender-based inequalities in access to and control over resources and in decision-making power. They may not have the information, time or permission from male heads of households to seek health care.

Poverty and social construction of masculinity interact to increase menôs vulnerability to specific health risks. Growing up in a poor neighbourhood and having to act out their male roles place adolescent and young boys/men at greater risk of violence and injuries. Because of their poverty, they may not be trained in any skill and have to depend on heavy manual work to fulfil their roles as breadwinners. Ways in which male sexuality is defined within contexts of poverty may encourage high-risk sexual behaviour and substance-use among young men. Men may be more exposed to seriously hazardous work environments than women.

For all these reasons, it is not enough to have health policies addressed to the general population or to the poor alone.

Limitations of some women-focused approaches

Even when an approach is women-focused, it may not be gender-transformative. The ñwomenôs health needò approach presents its rationale for focusing on women in terms of the synergy between womenôs health and child health objectives, and the cost-effectiveness of targeting women. Thus, women are addressed as mothers, and as a means to the end of improving household welfare. This narrow approach has been elaborated, for example, in the World Bankôs 1994 publication, ñ*New Agenda for Women's Health and Nutrition" (9)*. This approach is problematic for a number of reasons.

Gender-mainstreamed health policies

The ñwomenôs health needsòapproach is vastly different from mainstreaming gender in health policies. Gender mainstreaming health policies is important for reasons of equity, efficiency and rights (See Box 1). Gender mainstreamed health policies are more likely to achieve better health for women and men, through policies and programmes that are better equipped to meet the needs of the population. They contribute to narrowing health inequalities and promote the right to health of women and men from all sections of society.

Box 1. Gender perspective in health *(10)*

A gender perspective is essential to health policy because it:

- recognizes the need for the full participation of women and men in decision-making

- gives equal weight to the knowledge, values and experiences of women and men

- ensures that both women and men identify their health needs and priorities, and acknowledges that certain health problems are unique to, or have more serious implications, for men or women

- leads to a better understanding of the causes of ill-health

- results in more effective interventions to improve health

-contributes to the attainment of greater equity in health and health-care

World Health Organization: Health 21: The Health for All Policy Framework for the WHO European Region, Denmark, WHO-EURO, 1999.

For example, a 'gender-mainstreamed' health policy would recognise spousal violence as a gender related health problem to which women are disproportionately more exposed because of social norms sanctioning male aggression and their right to control women. It would examine environmental health hazards separately for men and women, and devise programmes to prevent and control exposure accordingly. It would provide for active tuberculosis case-finding to minimise under-reporting of infection in women, and examine whether or not women's biological differences contribute to their greater vulnerability to the infection, or to its consequences. Such a health policy would examine and correct gender disparities in human resources within the health sector and gender biases perpetuated by medical education.

More importantly, in the case of health issues specific to women, gender mainstreaming would involve addressing this need of women in a way that challenges existing gender roles and stereotypes. A 'safe motherhood' policy, for instance, would not assume either that women alone are responsible for childcare, or that they have access to the resources to ensure their own as well as their child's

well-being. It would be designed with awareness that women often do not have a say in whether and when to get pregnant. It would acknowledge that many pregnancies are unwanted or ill-timed from the woman's point of view, and would provide women with the option of safe pregnancy termination. Indeed, the policy would not even be called safe motherhood policy, but a safer pregnancy policy, allowing for the possibility of safe pregnancy termination.

Box 2 presents a tool for assessing whether a health policy has factored-in gender concerns or not. After this diagnosis, the policy would be systematically modified to

Box 2. A tool for gender-mainstreaming an existing policy *(11)*

1. Carry out an assessment of the potential impact of the policy on women and on men. Take steps to ensure that the policy does not result in a worsening of womenôs position in relation to men.

2. Ensure that there is an explicit statement as part of the policy vision, goals or principles of its equity intentions, including in relation to gender equity, and that the policy content is at the least, gender-specific, and preferably gender-redistributive.

3. The policy content should have factored-in differences in health and in access to health care between women and men resulting from gender-based differences in roles and norms and in access to and control over resources[1] .

4. There ought to be mechanisms for stakeholder participation in the design, monitoring and evaluation of the policy and explicit measures to ensure women's participation equally with men.

5. Disaggregated data should be collected on
- Input indicators regarding resources devoted to the intervention
- Process indicators monitoring the implementation of the policy
- Outcome indicators regarding achievement of the longer term objectives of the programme

6. The policy design addresses the influence of existing gender norms and practices at relevant levels[2] of the political and bureaucratic systems, which may obstruct the policy.

1 Note that this may arise from gender discrimination in laws and policies, or be a consequence of gender-based differences between women and men in roles and responsibilities or norms and values.

In other words, a gender-mainstreamed health policy would be ñgender-transformativeò It would seek to transform existing gender relations in a more democratic direction by redistributing more evenly the division of resources, responsibilities and power between women and men. In gender mainstreaming health policies, the focus is on equity.

The process of policy-making itself would be grassroots up, involving large- scale mobilisation at the grassroots level. Experiences from countries such as South Africa show that gender mainstreamed health policies, which evolve through this process reflect the priorities of the poorest and most vulnerable groups in society. A few informed feminists negotiating with the bureaucracy, without prior consultation with women from various sectors of society, would not be the way to go.

Another issue to bear in mind is that it is not sufficient to design a gender-mainstreamed policy in the health sector alone, if policies in other areas that have a bearing on health – all development policies for that matter – are gender blind, with an implicit male bias, and elitist, without a specific commitment to equity or the betterment of marginalized groups.

Example of an effort to gender-mainstream a health project in India (12).

In the early 1990s the government of India undertook an exercise, which included gender analysis, to inform the design of the new Tuberculosis control project. Planners hoped to get information that would help them understand why an overwhelming majority of patients did not complete their treatment.

Critical gender-related findings included that prohibitions against women's control of their own activities and of family finances were significant factors in their inability to comply with treatment regimens. Similarly, women's tendency to wait longer than men before admitting they were ñsick enoughòto seek care was found to be an important reason why both prevalence of and mortality due to TB among women was much higher. The stigma associated with TB among slum dwellers and tribal people was another important factor inhibiting women patients from openly seeking treatment. Patient perceptions about providers and ineffective communication between service providers and patients was also found to discourage people particularly poor/illiterate and semi-literate and women from seeking treatment for TB. This information allowed the project team to develop strategies to address these barriers.

---

[2] ‘relevant levelsô refers to each of the levels of the political system and of the bureaucracy at which decisions about this intervention will be made

3. Ensuring implementation of gender-mainstreamed health policies

3.1. Challenges

Ensuring the implementation of gender-mainstreamed health policies is a challenging task.

A variety of factors affect implementation of any policy. The national government may have underestimated the funds required; the agency responsible for implementation may deliberately undermine policy efforts that they consider inimical to their interests; implementation may be stalled for political reasons by a sub-national government that is led by a party in opposition to the national government, the technology recommended may not be suitable for field conditions; users/beneficiaries may not utilise the services because services are not affordable or are not of the desired quality; providers may not cooperate because they have inadequate support and supervision, do not have the requisite skills or incentives.

For gender-mainstreamed health policies the obstacles to implementation may be even more numerous. They often 'evaporate' even by the time that a policy statement begins to spell out concrete programme interventions, and almost completely disappear when they get to the stage of implementation. In an article entitled 'The evaporation of policies for women's advancement', Longwe argues that gender aware policies run contrary to the interests of bureaucracies which are inherently patriarchal in nature *(13)*. Government agencies are not and cannot be expected to be a means for redressing gender inequities because they are themselves a part of the problem and an obstacle to progress. She talks about the endless capacity of the government bureaucracy to evaporate policies for women's advancement.

Organisational changes within the health sector to mainstream gender is an essential prerequisite to enable as well as sustain the designing and implementation of engendered health policies.

In addition, the active involvement of civil society institutions and women's organizations is essential. Without the continued involvement and independent

monitoring by these actors, gender-mainstreamed policies may never be pursued but be given a quiet burial.

3.2. Preparing the ground

Mainstreaming gender in policy-making institutions

Mainstreaming gender equity within policy-making institutions has to go hand-in-hand with efforts at gender mainstreaming health policies. Unless this happens, it will not be possible to sustain gender-mainstreaming within all policies, plans, programmes and projects within the health sector. Kabeer (2003) identifies three major levers to bring about organisational change within policy-making institutions in support of gender-mainstreaming *(14)*:

" 1) The awareness lever: addressing the formal and informal norms, rules, attitudes and behaviour that institutionalise inequalities within an organisation. Gender training has been the conventional route to achieve greater awareness on this front. However, unless such training becomes a core aspect of organisational development, rather than made up of one-off, discretionary events, it will fall short of objectives. The awareness lever should be used to identify blockages to gender equity on a collective basis in the organisation.

2) The communications lever: the timely flow of information and analysis across the system in order that all policies and programmes are designed from a gender perspective. This requires investment in building up gender expertise across an organisation so that it becomes an aspect of different sectors rather than the property of a stand-alone group of gender specialists who are required to address all the governmentôs concerns.

3) The incentives lever: there has been a move towards performance-based appraisal within government as part of overall public sector reform. Staff members are increasingly assessed on their success in achieving the goals of government and of their departments. Gender mainstreaming requires that all performance appraisal systems incorporate incentives and penalties in relation to the achievement of gender equity goals*." (14).*

Advocating for change (15)

The political and social context is often hostile to changes necessary for the promotion of social and gender equity. It is important for health service leadership in strategic decision-making to acquire the skills to develop a strategic plan to gain support for changes. Strategic planning is also needed to ensure that the practical conditions for implementation are in place ï for example, resources mobilised, alliances and networks formed, and methods and messages for advocacy developed. Strategic planning should be based on an awareness of how change strategies can promote social and gender equity so that new policies and programmes jointly address practical, efficiency questions, and issues of equity and equality.

Members of the constituencies who the policy-change is meant to benefit: poor women and men ï need to be consulted and involved in the process of advocating for policy change. It is important to be accountable to this group, rather than speak on their behalf without a genuinely participatory process of consultation.

Influencing policy change is a complex process. However, with policy analysis as well as careful strategic planning, it is surely possible**.** There is no need to despair if an attempt to influence policy change does not succeed at a given point in time. What is needed is to wait for a change in policy environment and try over and over again. Major policy changes have always needed repeated efforts.