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8. Women's Health in India: Closing the Gender Disparities

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Abstract

Women are the primary healthcare providers in the family and make most healthcare decisions. The conditions of women's health need to be examined and understood. The social and cultural construction excludes women's health issues. This study aims to raise awareness about gender-based inequality in women's health. The research utilizes a qualitative approach to explore the gender disparities in women's health using a gender analysis. This study implies understanding how gender related inequalities affect women's health differently. The research finds that there is no doubt that the health of people is improving, but our healthcare system is not designed according to the gendered factors that influence the health status of women, nor has it adequately addressed women's health issues. The right to birth is denied by sex-selective elimination, and the right to survival is denied by the neglect of women and girls. Such gender-based inequality hampers societies' abilities to achieve sustainable development.

Keywords: Gender Disparity, Gender Analysis, Social Exclusion, Sustainable Development.

Introduction

Health is a fundamental right that is guaranteed in several human rights treaties (WHO Constitution, 1946; Sarojini, N.B. et al. 2006; United Nations, 2014). The 2030 Vision for Sustainable Development and Universal Health Care both support the idea that a rights-based approach to health should prioritize the needs of the most disadvantaged first to promote more fairness (UN General Assembly, 2015). Women in India come from a variety of socioeconomic backgrounds and are sometimes marginalized or neglected due to gender discrimination when it comes to essential healthcare (Khan, A et al. 2023; BMJ, 2019; Vilms RJ et al. 2017; Saikia, N., Moradhvaj & Bora, JK., 2016). One such issue is gender-based discrimination that can fetter the attainment of health goals such as those laid out as part of Sustainable Development Goal (SDG) 3 (good health and well-being). Until recently, "gender in the context of health" implied a discussion on women's health. However, an inclusive approach to health should

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attend to the needs and differentials between men, women, and other genders, along with the interaction between social and biological markers of health. Scholars have also highlighted the importance of an intersectional approach to health because women who have multiple subordinated identities may experience multiple layers of barriers and discrimination in accessing health services, This understanding is important in attaining universality in health coverage and is essential to achieve gender equality as Sustainable Development Goal 5 (UN General Assembly, 2015).

The World Health Organization's Commission on Social Determinants of Health (CSDH) embedded the goal of universal health care in strategies that include improving daily living conditions, tackling the inequitable distribution of money, power, and resources, as well as measuring and understanding health inequities (Birn, 2010; Smith & Krieger, 2008). Social factors, such as the degree to which women are excluded from schooling, and participation in public life, affect their knowledge about preventing and treating health problems. The subordination of women by men, a phenomenon found in most countries, results in a distinction between the roles of men and women and their separate assignment to domestic and public spheres. The degree of this subordination varies by country and social or cultural patterns within countries, however, in developing countries, it is most prominent (Iyyanar et al. 2020; Kalidasan & Arumugam, 2020). In India, there is a strong expectation that women should be submissive to the men of the household particularly to their father, brother or husband. It is often cherished as an important quality of a good woman.

In India, 226.3 million girls and women are married before the age of 18, with 99.8 million of those marriages occurring before the age of 15, which poses a serious threat to their health and welfare (UNICEF, 2022). Domestic abuse and human trafficking are additional factors that have an influence on the physical and mental well-being of women. These behaviors highlight the lack of control a woman has over her body and her rights. Numerous women who may be our coworkers, acquaintances, or family members may still be experiencing physical and psychological abuse but choose to remain silent about it (UNODC, 2011; Kaur, R., & Garg, S., 2008; WHO, 2007). This may be due to the societal expectation that women should be submissive.

Joanne Baily and John Arnold's work on "Is the rise of gender history hiding women from history again?" discusses how social constructions of discrimination lead girls and women to be more disadvantaged, as evidenced by the high rates of gender-based issues.

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In terms of gender inequality, India is ranked 140th out of 156 countries in the World Economic Forum's 2021 Global Gender Gap Report. In healthcare settings, prejudice and bigotry towards women in India might hinder them from obtaining the care they need. This may involve unfavorable attitudes on the part of healthcare professionals as well as a lack of knowledge about women's health problems (Panda, 2023). While gender disparity is the major cause of problems with women's health, there are other factors at play, such as the nation's subpar healthcare system (VIMSACIN, 2023). However, the government has worked hard to improve women's health conditions (The World Bank, 2023; WCD, 2016). Implementing policies and programs, such as those addressing gender disparities, is accompanied by some substantial issues (Dixon A., 2018). The current paper concentrates on these crucial elements and problems that have a bearing on women's health difficulties in India.

Research Methods

The study aims to raise awareness about gender-based inequality in women's health. Women in India face high gender biases and are subsequently more likely to experience disadvantages in their lives, especially when it comes to healthcare. The analysis presents gender disparity in the context of the consequences that impact women's health in India. The primary criteria for examining literature are the works that address the relationship between gender and health status in India. It uses a feminist lens to explore women's health-related gender disparities. The information's source is based on theoretical and empirical evidence gathered from several databases, including the National Family and Health Survey (Government of India), WHO, UNICEF, and various research articles and reports to describe the state of health-related gender disparities.

The study included theories on the "financial aspect," "social aspect," and "healthcare modernization" from a feminist perspective. The social element theory contends that, as responsible home managers of the family budget, women in particular should bear the brunt of price hikes' many social issues. Women's advancement in terms of development is negatively impacted by the expanding socioeconomic challenges associated with rising food prices (Reisch, L., Eberle, U., & Lorek S., 2013). According to the financial element theory, enabling women to work in finance will help women get equal rights and develop a gender-inclusive economy (Manji, A., 2010). The healthcare modernisation paradigm holds that women have universal and equal access to healthcare services. On the other side, discriminatory labor and

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healthcare restrictions hurt women's aspirations to live in a fairy tale and made them vulnerable to unstable employment, unsafe workplaces, and high rates of female infant mortality. Additionally, unequal healthcare infrastructure and the digitization of healthcare infrastructure foster varied inequalities and damage working-class women (Renner, J et al. 2021).

Women and Health Issues

The World Health Organization (1946) defines population health as "a condition of total physical, mental, and social well-being and not only the absence of disease or infirmity." In developing nations, where women face additional disadvantages and hazards to their health, these discrepancies are made worse.

The framework and principles of Universal Health Coverage (UHC) for India will be severely undermined if gender insensitivity and gender discrimination remain unaddressed. Gender disparities, particularly persistent anti-female biases, are most glaringly reflected in the declining female-to-male ratios among children below the age of six, with the sex ratio among children declining from 927 girls per 1,000 boys in 2001 to 914 in 2011 (Census of India 2011). In international demographic terms, a high-sex-ratio society is defined as one that has disproportionately more males, and a low-sex-ratio society has disproportionately fewer females (Kalidasan & Arumugam, 2020). Son preference is a deeply rooted value in Indian society and this is closely associated with the declining sex ratio and infant and child mortality (citation). Socio-cultural and biological factors together influence the overall demographic composition of a population and its sex ratio.

The concepts of health care in the country are not geared to take care of various problems related to women’s health. Most health systems tend to attribute women’s illnesses and physical complaints to their childbearing functions. Many organizations urge for a more inclusive definition that better describes "the health of women," as opposed to the more restrictive term "women's reproductive health," which is frequently used. Again, because of the focus on women’s childbearing functions, health care centers tend to focus on prenatal, natal, and antenatal care and neglect other health problems (Kasthuri, A., 2018). This is reflected in India’s ranking of 132 out of 134 nations in terms of gender equity in health (World Economic Forum, 2010). Furthermore, there remains a disturbingly high Maternal Mortality Ratio (MMR) of 212 maternal deaths per 100,000 live births (Ministry of Home Affairs 2011), despite the country's rapid economic growth rate (Economic Survey of India 2011). According to the Global Gender Report (2022), India is the worst performance in the world in the "health

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and survival" sub-index, where it is placed 146, and ranks 135 out of a total of 146 countries in the Global Gender Gap Index 2022.

With its deeply patriarchal society, the Indian context is especially relevant to study the effect of discrimination on health. Feminist theorists (Agarwal, 2003; Krishnaraj, 2010; Swaminathan, 2014; Iyyanar & Kalidasan, 2021) have made significant contributions to the understanding of how a rigid framework of socio-cultural mechanisms and the structure of gender relations results in the unequal position of women. The Nobel laureate Amartya Sen's (2001) work on gender equality is of seminal importance and he rightly pointed out many faces of gender inequality. While Pandey et al. (2002) find gender discrimination in rural West Bengal for the treatment of diseases like diarrhea. Gosoniu et al. (2008) find a greater delay in the diagnosis of tuberculosis in females. These differences in treatment-seeking behavior often result in worse outcomes for poor females (Sen, et al. 2007).

In the twenty-first century, accessing and affording healthcare services in India is difficult due to the millions of women and teenage girls who suffer from poor health and low social status. Women are typically more at risk for poor nutrition throughout their lives, which can influence their own growth and development and increase the likelihood that they will give birth to children who are underweight (Gragnolati, M et al. 2005). Women are frequently mistreated and abused, which has a detrimental effect on their general health. This is typically the result of gender-based discrimination and other societal abuses such as early marriage and dowry practice (Kalidasan & Arumugam, 2020; Agarwal, N & Milazzo, A., 2020). Abortions account for 14 percent of all maternal fatalities worldwide, it is difficult to provide easy access to safe abortion services. Even in places where safe abortion services are available, the stigma attached to abortion and the emphasis on motherhood, and the notion of 'purity' of women add barriers to women who intend to have an abortion. To enhance the quality of health, it is also important to raise awareness about sex, and contraception and address unmet family planning needs. An essential component of women's rights is offering women access to high-quality healthcare (Singh, P., 2020).

The healthcare system is not an exception to the rule that gender differences govern practically every aspect of our lives. However, the difference in healthy life expectancy between the sexes is only 0.1 years, demonstrating that women may not necessarily have healthier lifestyles than men. In India, women have an average life expectancy that is 2.7 years higher than that of men. According to experts, this gap results from women's health being

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negatively impacted by a lack of physical autonomy and resources. The social stigma and expectations related to women's intimate health have a big impact on the gender gap as well. Since 2019, India's position in terms of the gender gap has fallen from 112 to 140. As a result, marginalized women will have less access to healthcare (Sharma, 2022).

From Annapuranam's (2016) study, it is evident that the sociocultural aspects of women's experiences with poor health from a gender perspective have not received sufficient attention in the research. In particular, it has not been investigated how the changing processes of gender relations between the sexes and within the same sex impact the health of women in the contemporary environment. The interaction between men and women, how women see gender relations, acceptance of agency, negotiating with the social framework, and gender performance are all crucial aspects of interactive processes.

The High-Level Expert Group Report on Universal Health Coverage (UHC) for India Report 2011 says that the key issue is access to health services for vulnerable genders. Access is severely reduced by neglect that stretches from the family to the healthcare provider, especially for life-saving obstetric care, reproductive and sexual health services for girls, women, and transgender, along with poor health education and awareness for all genders.
There are several barriers to the provision of and access to health services, which should be factored in while framing recommendations for UHC. These include:

a) Political and legal barriers such as the misplaced emphasis on population control policies while fertility rates decline and the lack of political will for sexuality education and gender sensitization;
b) Economic barriers include user fees for maternal health services, the burden of healthcare loan repayment for lower-income families, and a lack of affordable public primary care services, which necessitates the use of private tertiary care.
c) Social barriers, such as the stigma attached to certain illnesses such as HIV/AIDS and depression,
d) Health system barriers such as the shortage of human resources for health, the lack of gender sensitization among healthcare providers, the lack of linkage and integration in current provisioning, which lacks primary care and rural coverage, as well as a lack of awareness of the provisions of the various schemes and programs for women (Planning Commission of India, 2011).

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The important constraints of the Indian health system are financial constraints, social constraints, and health sector constraints. The shortage of funds has been primarily responsible for the non-availability of facilities as per norms; the provision of inputs such as drugs, equipment, and facilities remain inadequate. Important social constraints are gender disparities, which are high in almost every segment of the health sector. However, the lack of a legal framework there raises the financial strain on the poor, preventing them from receiving health care. These circumstances broadens the scope of public-private partnerships. In the private sector, on the other hand, there are many unqualified doctors and there is a need for more trained practitioners (Planning Commission, 2013). In addition, there are spatial disparities, such as between urban and rural areas and across states. There is a need to promote women's health rights as a central component of efforts to strengthen health systems and protect women's health across the integrated life course (Kalra, 2019; Kalidasan & Arumugam, 2020).

Similar to other inequities, gender discrimination manifests itself in both lower health investments and it reflects the worse health status of women relative to men (Subramanian, 2008). This may be ensured through gender equity, gender mainstreaming (making considerations for and experiences with men's and women's health fundamental parts of the development, implementation, monitoring, and evaluation of health policies and programs), and empowerment (enabling individuals and communities to gain more control over their lives and to shape systems around them) (WHO, 2011). A gendered perspective would thus take into account the health needs of all categories (Krieger, 2001; Aron, 2022; Mehta, 2023).

Gender Disparities in Health: The Evidence for Tomorrow Agenda

Health inequities are defined by the World Health Organization Commission as "systematic differences in health that are avoidable by reasonable action and are quite simply unfair" (WHO, 2008). It proposes to terminate these systematic differences, i.e., close the gap in a generation, the space of 30 to 40 years, through action on the social determinants of health (WHA, 2009).

The difference between the genders is apparent in risk factors and disease burdens across the lifecycle, from childhood, through adolescence and adulthood, to old age (WHO, 2008; Kishor & Gupta, 2009). Analyzing the life cycle of women, it is clear that older women are more susceptible to maintaining their health and receiving therapy as they get older. Interventions must take into account the gender realities outlined above in order to effectively

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reach older individuals. The limitations on women's authority and autonomy that were discussed above also imply that elderly women do experience more difficulties than older males in gaining access to public services like healthcare. Gender expectations may make it harder for women than for men to seek treatment for some disorders, such as mental health issues. If interventions are to be truly effective, gender effects on older adults' skills and health-seeking behavior need to be explored and addressed (Kalra, 2019; Aron, 2022). According to Krishnaraj (2010), in order to examine reality from a more inclusive gender viewpoint, the study should include the perspectives of males as well. This would demonstrate how gender connections between agency and structure are evolving. Understanding how women describe gendered illnesses and the prevalent health-related attitudes and behaviors of women in different social groups are also crucial. It's essential to take into account not only the circumstances of the present but also those of the coming generations while tackling the health issue facing women.

Sugathan, Mishra, and Retherford (2001), McNay, Arokiasamy, and Cassen (2003), and Rustagi (2004) evaluated the status of women in India with different indicators such as women's work, education, health, survival, safety, and participation in public and private decision-making. This is an important issue because gender discrimination contributes to the poorer health status of girls than boys and is likely to be the main pathway for excess female child mortality. In India, excess female mortality and a preference for sons have existed for centuries (Milazzo, A., 2018). Indian censuses since 1872 have noted masculine sex ratios, which noted that there is no doubt that, as a rule, a girl receives less attention than would be bestowed upon a son. The girl is less warmly clad; she is probably not as well fed as a boy would be, and when she is ill, her parents are not likely to make the same strenuous efforts to ensure her recovery. There has been growing international concern on the issue of higher female mortality, a declining sex ratio, and missing females in India (Sen, 1990; Gupta & Bhat, 1997; Sudha & Rajan, 1998; Arokiasamy, 2004).

Rutherford and Roy (2003), Bose (2007) and Visaria (2007) examined the causes of eliminating the girl child. It indicates that they are rooted in rituals and perceptions that go back centuries: the fear of having to pay for a girl's dowry, the belief that for true salvation a son should perform the last rites, the conviction that lineage and inheritance run through the male line (even though legally both sons and daughters have equal rights to inheritance), and that a son will look after his parents in their old age, whereas the daughters belong to another family.

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All of this is linked to the old perception of seeing only men as breadwinners. In India, dowry-related violence, sometimes leading to deaths by murder or suicide, is increasingly being documented (Iyyanar & Kalidasan, 2021; Milazzo, 2018).

The wealth gap between men and women is a key aspect of health in this setting. In both urban and rural India, women are substantially less likely than men to be wealthy (Jose, 2011). According to Friedrich Engels (Keister & Southgate, 2012), this is the outcome of a patriarchal culture where male dominance is more pronounced in economic ties. Even though the Hindu Succession Act of 2005 guarantees equal inheritance rights, women continue to face significant discrimination in the allocation of inherited money. Due to their lower wealth, women are at a disadvantage and may even be at the root of more general trends of inequality in India. It is undeniable that land is a valuable resource in addition to providing millions of poor people with a vital means of subsistence.

Women in many parts of the world receive less attention and health care than men, and girls in particular often receive far less support than boys. As a result of this gender bias, the mortality rates of females often exceed those of males in these countries (Sen, 2001). Sridar's (1996) study provided evidence that boys have better access to care for Insulin-Dependent Diabetes Mellitus (IDDM) than girls. The reasons were not studied, but food preference likely plays a role here, in keeping with other health-related research findings. Sridhar noted that mothers tended to take responsibility for looking after diabetic children, which could result in alienating fathers and making them uninterested in helping to care for their children.

The Indian healthcare system requires discussions, advocacy, and research to underscore women's health as one of the focus areas in research and implementation. Such a process can be informed by similar work done elsewhere. For example, sex-disaggregated analyses of data have shown that women with diabetes have a 44 percent higher risk of heart attack than men with diabetes (Huxley, et al. 2015). Similarly, women with diabetes have a 27 percent increased risk of stroke compared to men with diabetes. Given the fact that South Asians are at increased risk of cardiovascular disease, especially at a younger age, such sex-disaggregated studies are much needed in India. All sections of society, including men, need to be involved in promoting women's health (The George Institute for Global Health, 2016; Woodward, 2019).

Due to women's dual responsibility for both household and outside work, and their lack of decision-making power and often arduous tasks in the workplace, female managers tend to

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experience more negative stress than men (Kalra, 2019; Karasek, 1979). In several studies, it has been shown that women at all levels of employment reported more such stress. For example, women who had to work more than ten hours of overtime per week had a higher risk of heart attacks than other women, whereas men who worked the same amount of overtime were at a lower risk (Oslin, 2000; Swaminathan, 2014).

The area of reproductive health includes both men and women. But the reproductive health rights of men and women need to be talked about separately. Especially in the Indian culture, women's reproductive rights need to be discussed, as women are considered secondary and there is a stronghold of deeply rooted patriarchal thoughts in all spheres of life (Iyyanar et al. 2020). Women's bodies are viewed as machines for childbearing and raising children. Women's bodies are controlled for several reasons, and there are social and religious sanctions for the same. The women are targeted for population control. They are not perceived as human beings and are treated as objects. They are not participating in policymaking and also are not decision-makers in their personal lives (Anjali, 2010; Kalidasan & Arumugam, 2020).

Since health data are not often gathered and evaluated separately by sex, it is frequently quite challenging to determine whether a specific health concern has a distinct incidence, prevalence, or death among men as opposed to women. Even when they are, research papers frequently omit gender analysis—that is, an examination of the various effects and circumstances of a specific disease for males as opposed to women. For our knowledge of the relationships between gender, health, and health-seeking behavior to advance, both of these issues must be resolved (Ravindranath, 2013).

The Evidence for Tomorrow Agenda

The World Health Organization's Commission on Social Determinants of Health (CSDH) defines the Social Determinants of Health (SDH) as the conditions in which people are born, grow, live, work, and age, including the health system (WHO, 2003). It encourages countries to provide Universal Health Coverage to address health inequity directly. Furthermore, the report acknowledges that health inequities arise not only from within the domain of health, but also from outside of it, through other social determinants such as "unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives - their access to health care, schools, and education, their working and leisure conditions, their homes, communities, towns, or cities" (Kalra, 2019; Iyyanar et al. 2020).

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The Millennium Development Goals place health at the heart of development. Improvements in health are important in and of themselves, but better health is also a prerequisite and a major contributor to economic growth and social cohesion. Economic capabilities affect health, as low-income households have limited access to health care and health-promoting opportunities. Equally significant is that ill-health limits people's ability to earn higher incomes and contributes to poverty. It is therefore important that the health-related MDGs are not seen in isolation as a discrete programme (Kalidasan & Arumugam, 2020).

According to Buckshee (1997) study, despite India's leadership in the development of health and population policies, there have been significant implementation issues because of poverty, gender inequality, and illiteracy. However, women in India produce three-quarters of the country's annual food production. The literacy rate among Indian women was only 39.3 percent in 1991. The degree of literacy among women can have an impact on sexual behavior, the use of contraceptives, children's health and upbringing, good hygiene habits, employment opportunities, and the general status of women in society. The socio-economic underdevelopment that still exists in India is largely due to early marriage and childbearing, which were also important factors in determining women's health. With a national average of 572.3 per 1,00,000 births and regional variations of 14.9 percent in Bihar and 1.30 percent in Kerala, maternal mortality is a problem in India. Statistics show that 64.4 percent of maternal deaths are caused, indirectly, by anemia. Between 60 and 80 percent of all female births are assisted by trained birth attendants. Maternal deaths are largely caused by socioeconomic factors, with money accounting for 18.3 percent and transportation accounting for 13.7 percent. When a mother passes away, her boys who are still alive have a twofold increase in mortality risks, but her daughters have a fourfold increase. The most significant preventable cause of maternal deaths is a lack of prenatal care. If women are informed and educated, they may help their children's health by practicing simple habits like proper nutrition, exercise, and hygiene. Because of poverty, many of the young children, especially girls, living on the streets are easy prey for drug trafficking, criminal prostitution rings, the consequences of HIV infection, and severe emotional and mental disturbances.

The Convention on the Elimination of All Forms of Discrimination against Women, Article 12 (CEDAW) clearly states women’s rights regarding health. It recognized access to health care, including reproductive health, as a basic right. Reproductive and sexual rights are within the human rights discourse. Reproductive and sexual rights, which have emerged in

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discussions and campaigns around women's health, and subsequently into the discourse of women's rights, are human rights (UNHR, 1979). The International Conference on population and development (ICPD, 1994) articulated the concept of reproductive health in a manner that boosted the efforts of women's health advocates, who have been leading the campaign for protection and promotion of women's rights to their bodies and reproductive decision-making.

The National Health Policy (2002) noted that social, cultural, and economic barriers still prevent women from having proper access to healthcare, even at the public facilities that are already in place. Even though the term "gender" was not used specifically, it is intended to give women more access to essential healthcare facilities by viewing women through a gender lens. It highlighted the considerable disadvantages faced by women and other disadvantaged groups due to their disproportionately limited access to health care. UNICEF (1998) study pointed out that girls in India are discriminated against in other ways as well as fewer months of breastfeeding, less nurturing and play, less medical treatment if they fall ill, less special food, and less prenatal attention. As a result, girls are far more susceptible than boys to disease and infections, leading to poor health and a shorter lifespan. It is this lifelong discrimination in nurturing and care that is the real killer of girls, less visible and less dramatic, but as unequivocally lethal as female feticide and infanticide.

Bhat and Zavier (2003), Roy and Rutherford (2004), Pandey (2003) and Acharaya (2004) explained the extent of gender differences in infant and child mortality in terms of gender differences in health status, disease incidence, preventive and curative treatment and social status. Gender differences in the social determinants of nutrition can also be found in industrialized countries. For example, gender plays an important role in determining risk factors for eating disorders, which influence nutritional outcomes. The most common of these are anorexia nervosa, bulimia nervosa, and binge eating (Gandarillas et al. 2004; Austin et al. 2004).

Women's health is correlated with their position in society and the culture that exists there. The socio-economic environment has given rise to numerous health problems. PCOS, breast cancer, ovarian cancer, menopause, and other ailments that affect women's health are among them, but there are a few other illnesses that we often neglect that are killing our female population. A healthy woman assures a healthy family, so as a society, we must actively seek to ensure that our women are in good health. Women are not the weaker sex; rather, society has created them that way. More awareness efforts, education camps for rural women on the

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aforementioned topics, programs, and campaigns are needed in order to alter mindsets and save our women (Iyyanar et al. 2020).

In India, women are underrepresented in the formal labour force and in education. According to studies on women's status, Indian women's contributions to families are frequently disregarded in favor of being seen as financial liabilities. In terms of women's health, reproductive rights receive the least attention (Aron, 2022). To improve the quality of health, it is also important to raise awareness about contraception and address unmet family planning requirements. Underprivileged health affects not only women but also their families. A woman's health has an impact on the household's financial well-being since women in poor health are less effective workers (Kalidasan & Arumugam, 2020; Gupta, 2022).

The gender differences in the social, economic, and biological determinants of health are examined in this section. In patriarchal societies like our own, women's health challenges have historically gone unnoticed. The male-dominated community still ignores or marginalizes many of the problems that women face (Iyyanar & Kalidasan, 2021; Aron, 2022; Mehta, 2023).

Mainstreaming Gender in Health: A Framework for Action

Carol Vlassoff's (2007) study shows that in both developing and developed countries, awareness of the importance of gender analysis in health is growing, with respect to both infectious and chronic diseases. Despite a rapidly expanding literature in this area, comprehensive, integrative analyses are few. It is difficult to compare the studies in this field as they are based on populations with different ethnic, socioeconomic and demographic characteristics, different geographic and ethnic groups, and different diseases and health conditions, or different symptoms of these diseases and conditions. Moreover, these interrelationships may change over time, with, for example, changes in marital status, age, or social and economic conditions. As a result, in-depth gender analyses of women's health and well-being are very few.

Spurred by these data, many organizations and documents have highlighted the need to develop a holistic, life-course agenda for women's health that does not abandon them once the childbearing age is passed. These include the Every Woman Every Child Movement (2010), WHOs recognition of women's health beyond reproduction as a new agenda (2013), the Lancet Commission on Women and Health (2015), the Global Strategy for Women's, Children's and Adolescents Health (2015), and the Global Leaders Meeting on Gender Equality and Women's

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Empowerment by the UN (2015), leading to commitments by the UN member states. The gender disparities are evident in the provision of health care, all to the disadvantage of women in India.

Govidarajalu (2011) study explores the ideas that good health is both the means and the end of development. It has been identified that improved health contributes to economic growth in four ways. It reduces production losses, permits the use of natural resources, increases the enrolment of children, and allows for alternative uses of resources that would otherwise have to be spent on treating illness. This health improvement is an important factor in nation-building.

The Indian Constitution has granted equal rights to all its citizens and recognizes that there will be no discrimination based on class, caste, religion, race, or gender (Article 15). Still, in reality, it is found that women's status is secondary in society. It gets reflected through various development indicators. Health is one of the important indicators that throw light on society's attitudes toward women. The declining sex ratio is because of an increasing number of sex-selective abortions, the declining nutritional status of women of all age groups, and alarming rates of violence against women, among other issues of concern (Kalra, 2021; Aron, 2022).

As son preference and acceptance of violence decline, families will be more likely to educate their daughters, and the age of marriage will rise. As women are better nourished and marry later, they will be healthier, more productive, and give birth to healthier babies (Kalra, 2021; Agarwal, N., & Milazzo, A., 2020). Discrimination against women can only be eradicated through action and remedy, which was the vision of India's independence: in India, all people have an equal chance to live and achieve healthy and productive lives. There is a need to provide stronger evidence to demonstrate the importance of health consciousness and government programs for women's health. Otherwise, the ongoing health investments will lead to diminishing returns and will not benefit women or the nation at large (Iyyanar & Kalidasan, 2021).

Humanizing healthcare services along with education can be the most significant intervention to make women conscious of their rights and prevent them from becoming easy prey to severe emotional and mental health problems. The health issues facing women will benefit from giving them employment possibilities (Iyyanar et al. 2020). Female healthcare professionals can make a significant contribution to society's awareness of its own nutritional

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and health demands. Additionally, empowering women at all levels would enable them to contribute positively to society and raise healthy future generations (Singh, 2020).

Sustainable Development Goals (SDGs) focus on a way forward for the global development agenda. Among all the goals, health assumes the centre of the development agenda. Improvements in health are important for their rights and a prerequisite for economic growth and social cohesion. Targets set in the national health policy, national population policy, eleventh five-year plan, and Millennium Development Goals are in tune with those under the SDGs. Some of the Indian research targets for health-related SDGs are ambitious. Although some progress has been made toward achieving these goals, much more remains to be done.

Conclusion and Implications

Research on women's health has shown that most women in India are still not receiving health facilities. The study found that gender disparities play a role in the determinants and consequences of women's poor health (Iyyanar et al. 2020). Women's poor health can be seen in their lack of access to nutritious food, anemia prevalence, and nutritional status. It leads to high mortality rates for women in India. Indian women's social standing and health are inextricably intertwined. Social and culturally constructed discrimination against women must be eliminated in order to close the gender gap in access to women's health care (National Sample Survey Organisation, 2014; Aron, 2022).

Gender analysis is key to eliminating gender disparities in women's health care issues. Every health-related research should be designed in such a way as to facilitate the inclusion of gender analyses. Sex-disaggregated data will lead to better planning and implementation of women-centric health interventions (WHO, 2015). Sensitization programmes for all young people that include key elements of gender power relations, and their health consequences. There is a need to raise the voice against gender disparities in health care facilities and to improve the status of women at every possible level, and this should not stop until and unless this problem is removed from society. This would be crucial to the attainment of the SDGs. There is a need to carry out a comprehensive and independent evaluation of all new and existing programs to determine how investment in gendered research can provide new knowledge and lead to improved policy implications.

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