A critical assessment of Health Policy and its impact on women

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April 1996
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Investing in women is not a panacea. It will not put an end to poverty, remedy the gross inequalities between people and countries and slow the rate of population growth, rescue the environment, or guarantee peace. But it will make a critical contribution towards all those ends. It will have an immediate effect on some of the most vulnerable of the world's population. And it will help create the basis for future generations to make better use of both resources and opportunities (UNFPA).

I. Introduction

Until quite recently, attention to womens' health, within the modern paradigm, has most commonly focused on the reproductive processes and organs, and on the child bearing period, which is generally defined as between the ages of 15 and 44. Occasionally the health of girls has been considered, but again, primarily within the context of concern of assuring future reproductive health and the health of children. Most discussions on womens' health, especially with respect to developing countries, have referred only briefly, if at all, to health problems apart from reproduction or to post menopause. This continues to have important implications for health policy and planning, especially in era of global economic recession, and at a time when comprehensive primary health care is being challenged and selective programmes are being offered as alternatives. (Raikes, 1989). This paper critically assesses the evolution of health policy and its impact on womens' health. Section II of the paper defines the concepts of health and development and explores the relationship between

the two; section III looks at the health policy in context to the developing countries from the 60s onwards till the present decade and its effect on women; and section IV raises policy issues that challenge development institutions and policy makers in the 90s.

II. Health and Development:

The concepts of health and development, have always been an issue of debate. However, for the purposes of this paper the WHO definition of health will be used, defining health as `a state of complete physical, mental and social well being and not merely the absence of disease or infirmity'. This definition not only implies a complex interaction between humans and their environment, but also emphasises the important role played by social and economic factors and the manner in which they interact with the biological and environmental factors. Seers(1969) defines development as of necessity increasing aspects of human dignity - which means access to basic needs; food, shelter, a job - and also political participation. Development is therefore generally understood as the process of improving the quality of all aspects of human life (WHO 1992a). The relationship between health and development is a complex one and has both `reciprocal and synergistic' (Phillips and Verhasselt, 1994) elements to it. Poor health of a large majority of individuals can limit the overall growth of a nation. On the other hand, a high national growth rate can lead to an overall improvement in the health status of the community.

It is important to realise that many development policies designed to improve living standards and economic conditions of communities can have unexpected or unintended

effects on health. Phillip terms these as `health by-products' of industrialisation. However, within communities, which are by their nature heterogeneous the development process affects individuals and groups differently. Class differences have been acknowledged and analysed conventionally. Less often considered are the differential effects of development on women and men (Ferguson, 1986). Furthermore the contribution that men and women make to development differs overall, at various stages of the life cycle and also among socio-cultural groups. The value placed on these contributions by society and by different development agencies also varies.

Women are often at the critical `cross points ' of health and development. As in many domains, they occupy the pivotal position between policy and practice in health (Smyke, 1991). Over the last two decades, the adverse effects of development on women on the one hand, and the centrality of womens' roles in economic development, on the other have been acknowledged by activists, practitioners and perhaps belatedly, scholars.(Lewis and Keiffer, 1994).

That is why it is critically important to analyse health policies and ensure that their impact on womens' health will be positive.

III. Evolution of Health Policy:

Health policies in most of the developing world presently discriminate against both men and women. Women are denied curative care outside their reproductive roles. They are provided especial attention only because of their biological role in reproduction. They are thus looked at as mothers and wives. Health needs outside this

reproductive age group are overlooked. Men on the other hand have better access to curative care which maybe because of greater access to and control over resources and decision making power within the household and the society.(Beall 1995). Mens' participation in preventive and promotional programmes is not actively sought which keeps them from getting involved in reproductive roles. Thus the present day health policy accepts the gender division of labor and responsibility and further reinforces it.

The decade of 60s, emphasised worldwide the process of development through accelerated growth; market economy was considered to be the most fair distribution mechanism and it was hoped that the benefits of growth would trickle down to people at all levels as the society developed by transition through several, almost predictable stages. The developed countries offered a blue print of development, having already undergone the previous stages, which the underdeveloped countries were still struggling at. It was therefore natural that health policies and medical services in the developing nations were modeled on those of Industrialised nations. The emphasis within this framework was on sophisticated hospital based treatment (serving better off urban dwellers). This lead to vast expenditure on imported equipment and drugs/ western trained staff and sophisticated hospitals. A growing concern with communicable diseases led to a large proportion of public health resources being consumed by centralised curative medical services and vertical disease eradication programmes. (e.g. eradication of small pox).(Beall, 1995). Professionalisation of health care also led to it becoming a masculine preserve.

In this context women were viewed as passive and dependent beneficiaries of development. Implicit was an assumption of families as corporate units with male heads and in which assets and resources were distributed equally.(Beall, 1995) Another assumption was that an overall improvement in the situation of a family would automatically imply an improvement in the health status of women.

The optimism of the 60s soon gave way to disillusionment in the 70s. It was increasingly observed that the benefits of growth had not trickled down to the poorest communities, nor had the position of women improved where overall incomes had increased. An increasing concern with growing impoverishment led to a shift in development policies and poverty oriented strategies were introduced. This framework emphasised basic needs or access by the poor to employment and productive resources and provision of basic services.(Beall, 1995)

The WID lobby demanding equal opportunities for women gained strength in the 70s. The UN decade for women (1975-85) was declared and increasingly analysis linked womens' poverty to underdevelopment and their marginalisation. This led to promotion of policies that would increase womens' income generating opportunities increase and their access to basic health services (esp. family planning). It was in this context that the Primary Health Care (PHC) initiative was launched at Alma Ata in 1978. It was hailed by the World Health Organisation (WHO) as `the most optimistic statement of purpose ever made by the world community'. PHC ushered in a new approach to health care that stressed equity, health promotion and prevention of disease. The World Health Assembly's proclamation of `Health for All by the Year

2000', with PHC as its centrepiece, also held great promise for women - for the masses of women whose health needs were unmet, for the masses of women who, as health care providers, needed recognition and support (Smyke). The new approach tried to devolve responsibility away from professionals and return it to the community. There was an attempt to decentralise health provision and increase preventive health care, focusing on the causes of illhealth rather than curative care, which mainly addressed the conditions of ill health.

However, in reality despite its potential the PHC approach did not breakthrough the structural gender barriers that continued to force on a majority of women daily drudgery and keeps them away from all development interventions. The approach was challenged by feminists on several grounds :

The PHC approach envisaged community participation as a key element in its efforts towards decentralising health care. However, the community was considered a homogenous entity and the inherent conflicts, both inter households and intrahouseholds were not addressed. In reality communities are heterogeneous, with different socio economic groups and different ethnic, clan, religious or caste group. Gender differences exist amongst all these where socially constructed roles between men and women determine the sexual division of labor in that community or family. These diverse groups have different access to resources, different survival strategies as well as different health care needs. Strategies to address these complexities have been poorly articulated. Experience indicates that women, especially poor womens' health needs were ignored.(Kabeer and Raikes, 1992) Generally the decision making roles

has gone to men, not from the poor or backward caste groups- as panchayat/ village committee members.(Raikes, 1992). The male dominated medical establishment has tended to identify health needs according to its own preconceptions and biases. Womens' own health concerns have often been overlooked and they are seen primarily in their roles as mothers and wives (Kabeer and Raikes). This has also been evident in the disproportionately high budget allocation and focus on the child component, and has led several to question as to `where has the M disappeared in the MCH'.(Shah and Gandhi, 1992)

Also, all the tasks identified as essential within the PHC approach (nutrition, immunisation, sanitation, drinking water etc.) fell within the domestic realm. This led policy makers to focus completely on women to the exclusion of men. A simple, almost naive, view of community participation led to the implicit assumption that women would `volunteer' time, resources and skills at the grassroot level. This not only added to the already long list of tasks a woman has, but characteristically (as a womans' vocation) remained an unpaid or at best lowly paid service.(Kabeer and Raikes, 1992). The exclusion of men has further been enhanced by a vertical approach targeting women through a parallel set of programme implementation activities.(Beall, 1995). Men have continued to abdicate all responsibility in matters of caring, nurturing and other aspects of health. And the policy makers have facilitated this by failing to acknowledge men as important actors and decision makers, especially in sexual and reproductive health.

The nature of health policy, with its emphasis on MCH and FP, has led the feminists to challenge that "in the minds of the policy makers, MCH figures not as an independent programme but as a means to reduce fertility" (Gupte M. 1986). The all encompassing attention on targets (be it immunisation/ sterilisation/ ORT etc..) have reduced women further to objects and has added State as another institution that gained control over womens' bodies. Knowledge that would have empowered her, (about her body and its processes of reproduction, menstruation etc.) did not figure on any list of priorities. The modern medicine completely disregarded the vital role that women had been playing as health care providers within the traditional medicine system. The women continued to play these roles, especially where access to modern health services was difficult, only the system termed them as `untrained' or just ignored the potential that existed in them.

If the 70s was the decade of disillusionment, the 80s have been termed as a `harsh decade' by Julius Nyerere. And harsh it has been with economic recession, debt and adjustment policies, internal and international armed conflict leading to massive displacements of people, as the legacies of this decade. And all this have had as especially devastating effect on women and children. In the State of the World's Children 1989 UNICEF reports :

> *"Over the last few years, a decline in health spending per person has been documented in more than three quarters of the nations of Africa and Latin America, and the decline is almost certainly more widespread than these figures suggest... The incidence of low birth weight, a sensitive indicator of the well being of women, has increased in 7 nations out of the 15 for which recent information is available."*

The health status concerns need to incorporate issues of sexually transmitted diseases, AIDS/infertility and sub fertility, safe contraception, gender differences in health throughout life, but particularly in adolescence and after the age of 60. Related Issues such as violence against women (domestic & community), and prostitution need to be brought in as mainstream health issues affecting womens' health. Health service concerns need to look into gender differences in access to and utilisation of health care, ability to pay for care, health insurance, womens' health knowledge and practice ranging from perception and use of traditional medicine to involvement in western biomedical systems and access to counseling.(Lewis and Keiffer, 1994)

The challenge of the nineties for the social policy planners is to influence policy and public action, while recognising the constraints imposed by SAP and expenditure cutbacks. Complex strategies need to be evolved to make use of available opportunities within the system and advocacy and lobbying to create new opportunities.(Beall, 1995). The image of women as passive, subservient, silent beings needs to be recognised as just that, an image. The womens' movement has gained momentum over the last two decades, and several aspects of womens' health have been addressed by the womens' movement. It is important that the policy makers step out of their ivory towers and make an attempt to listen to these voices. Networking efforts with womens' groups, other autonomous peoples' groups need to be strengthened along with a political commitment to involve them at all levels of planning. An openness and willingness to try out new and creative strategies will mark 90s as a different and a more hopeful decade in which womens' health needs are addressed.

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