REVIEW ARTICLE

Gender Issues in Health Sector

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Abstract:

Gender wise analysis of data brings out biological, behavioural and social variables which indicate inequality in the health parameters in male and female sex. There is discrimination against women. Right to birth is denied by sex selective elimination, right to survival is denied by the neglect of girl child resulting in declining trend of child sex ratio which has reached an alarming low level of 914 in 2011 in spite of the fact that the female sex is biologically stronger.

The mortality and morbidity indicators are un-favourable to the females. Maternal mortality in developing countries including India is unacceptably high. There is a failure of achievement of Millennium Development Goals in relation to maternal mortality and gender equality and empowerment of women. Crime against women is increasing. Violence is domestic or at workplace or occurring in public places. Social factors like male dominance and subordinate status of women make them vulnerable to unfair treatment, discrimination, denial of basic human rights to survival, education, health, inheritance, etc. The preventive measures in the form of education of masses for effective change in behaviour against gender discrimination, provision of facilities for achieving gender equality, and legislative measures for controlling violence against women at domestic and public level need intensification to achieve social justice of gender equality.

Keywords: Gender, Maternal mortality, Millennium Development Goals

Introduction:

Among all the disciplines of sociology the health sciences is the first one which perceives the gender issue due to two reasons. The public health sector regularly assesses the health of the community for varied purposes including planning. There is a vast list of indicators which directly or indirectly give information about different aspects of the entirety of community health. The health outcome indicators are most popular as well as informative among the prevailing health indicators. Health determinants are also commonly measured. Among the determinants the indicators pertaining to the system of providing health care are also calculated as they form the most important determinants. In spite of the service provision the utilization rate varies widely for several reasons. Countrywise or statewise comparison of health of the community by compiling some of these indicators is regularly published. The average health indicators may be satisfactory. The scrutiny of segregated health data by sex acknowledges sex (biological) and gender (behavioral and social) variables more than in other social sectors.The United Nations Development Programme has also started calculating Gender Inequality Index along with Human Development Index report separately. Secondly in case of any adverse event

the first point for care seekers is health system.

Assessment of Indicators:

Mortality Outcomes

The health outcomes are typically grouped into mortality and morbidity indicators. Age related mortality rates from report of the Sample Registration System for the year 2013 [1] are given in Fig. 1.

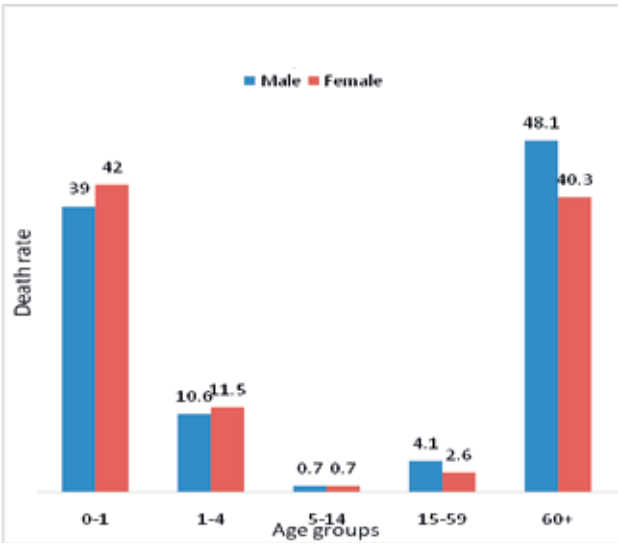

Fig. 1: Sex Differential Death Rates 2013, India

The view clearly indicates higher mortality among female infants and one to four year's age group. The mortality is equal among 5-14 years age group population. Then there is a shift; the mortality among males is higher. One can very easily deduce the reason for higher mortality in girls before five years of age; as they are totally dependent and neglected. Probably the impact of exogenous socio-economic factors gets lessened. The crude death rate among males (7.5) is higher than among females (6.4). Naturally longer life expectancy at birth among females (69.3) than among males(65.8) is usually observed in India including SRS report for 2009-2013 periods [2]. This is in consonance with general knowledge that female sex is biologically stronger.

Morbidity Outcomes

The morbidity reviews also disclose higher prevalence rates of both communicable diseases and non-communicable diseases among females than males. Among females the period prevalence for last 15 days (46.47/1,000) was higher than among male population (42.51/1,000). This has clearly emerged from NSS 60th round in 2004 [3]. It also documented that majority of the auto-immune disorders like Systemic lupus erythematosus, Sjogren's syndrome, Hashimoto's thyroiditis, Grave's disease, Rheumatoid arthritis, Multiple sclerosis and Primary Biliary Cirrhosis etc. are far common among females [4].Women across the world including Asia, Africa, and the industrialized countries are reported to have blindness clearly in excess than the males. It is estimated that women bear approximately two-thirds of the burden of blindness in the world (5).The comparison of Disability-Adjusted Life Years (DALY) of both male and females clearly indicate that the global DALYs lost to females for sexually transmitted diseases such as gonorrhea and Chlamydia are more than ten times higher than those of the males [6].

The female mortality due to HIV/AIDS is certainly higher. This is glaringly observed in the worst affected region of Sub-Saharan

Africa, where women account for 60% of all adult HIV infections [7].

Alzheimer's disease and other dementias and secondly unipolar depressive disorders are observed more among females in the ratio of about 1.64 to 1.53. Depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% among men [8].Osteoarthritis also affects women disproportionately with female to male ratio of about 1.81 [9]. The iron deficiency anemia in women probably tops the list of non-communicable diseases. A woman has some predisposing biological risks for anemia. Almost half of Indian women are anemic and the prevalence seems to be unabatedly increasing [10].

Biological Sex Related Health Outcomes:

Maternal Mortality

The scenario of mortality and morbidity indicators related to biological factors is appalling. The first indicator which strikes mind is Maternal Mortality Ratio. The maternal deaths were not given attention which they needed. Malcolm Potts the World Health Organization's Interregional Meeting on the prevention of maternal mortality on11-15 November 1985, for the first time projected the shocking scenario of maternal mortality in very catchy words comparing the tragedies to aircraft crashing. This attracted international attention towards maternal mortality [11]. "Every four hours, day in, day out, jumbo jet crashes and all on board are killed. The250 passengers are all women, most in the prime of life, some still in their teens. They are all either pregnant or recently delivered a baby. Most of them have growing children at home and families that depend on them". In the same meeting, Mahmoud Fathalla, described how a woman can die a maternal death and how prevention is possible at every step. He as the President of International Federation of Gynecology and Obstetrics was person instrumental in creating technical and social awareness about maternal mortality. "Women are not dying because of a disease we cannot treat. . . . They are dying because societies have yet to make the decision that their lives are worth saving" [12]. It clearly points that the gender discrimination is resulting into such a high maternal mortality ratio. Students from medical colleges since decades have been taught and know that pregnancy and delivery is associated with risk. These are natural processes in the life of a woman. The latest data from countries where quality of services and social environment which includes gender perspective is better indicates the risk is really minimal.The countries having very high and very low values of MMR from the latest available data are given in Table 1.

Table 1:Global disparity in Maternal Mortality Ratio, 2013

Country	MMR
Belarus	1
Israel	2
Poland	3
Austria	4
Finland	4
Iceland	4
Italy	4
Norway	4
Spain	4
Sweden	4
Burundi	***740***
Somalia	***850***
Central	***880***
Chad	***980***
Sierra Leone	***1100***

Source: [13]

In 2005 the highest MMR was 2100 times higher than the lowest one (1 and 2100) [14]. Although the disparity is still high, there is some improvement. The ratio of disparity as well range of Maternal Mortality Ratio (MMR) has been reduced to 1: 1100.Similar scenario of disparity and range and the trend in India is shown in Table 2.

Table 2: Disparity in Maternal Mortality Ratio, India

Year	Worst		Best	
	State	MMR	State	MMR
1997-98	Uttar Pradesh	606	Tamil Nadu	131
2011-13	Assam	300	Kerala	61

In the report pertaining to period 1997-98, Gujarat was shown to have least MMR of only 46 but subsequent reports had shown high MMR and the first figure has been ignored in Table 2. The disparity ratio has slightly increased from 1:4.6 to 1:4.9 or one may infer that it has almost remained same at about 1:4.75. But the range has certainly decreased. Earlier in 1997-98, it was 131 to 606 (475). Recently in 2011-13 it has been reduced and ranges from 61 to 300 (239) [15, 16]. It is sure that the trend is declining. Maternal mortality is a typical iceberg phenomenon, for every woman who dies; some 20 others face serious or long-lasting consequences. This concept is not getting attention it needs.

Cervical Cancer

It is one of the leading causes of cancer deaths among women in India, with approximately 1.32 lakhs new cases of cervical cancer being diagnosed and about 74,000 deaths estimated annually, accounting for nearly one-third of cervical cancer deaths across the world. Yet the uptake of Pap smear is poor and the decision about Human Papilloma Virus vaccine is pending for various reasons.

Breast Cancer

It is the most common cancer in women all over India and accounts for 25% to 31% of all cancers in women in Indian cities [17]. We are witnessing an age shift, and the average age of developing breast cancer has shifted from 50-70 years to 30-50 years. The breast cancer in the young tends to be more aggressive. According to GLOBOCAN [18], for the year 2012, an

estimated 70,218 women died in India due to breast cancer, more than any other country in the world followed by China with 47,984 and USA with 43,909 deaths, even though the population of China is more than India. However the detection of cases has exactly reverse ranking.

Males also have higher morbidity and mortality in few diseases and mostly due to presence of exogenous risk factors like tobacco smoking, rash driving etc. These are behavioral related and are always condemned.

Underlying Factors:

Social Factors

The root factors are intricately woven biological and social environmental conditions. Although sex is biologically defined, gender roles are socially construed. Norms, expectations, behaviours, roles for men and women in society are prescribed socially. The work or value of work the women perform is neither recognized nor adequately paid. The financial deprivation leads to secondary role. Women have less access to productive resources, assets, decision making, and mobility. This results in unequal power relations between men and women leading to subordinate status for women making them vulnerable. Not only vulnerable but when needed there is unequal treatment, discrimination, denial of rights in education, health, inheritance etc. The girl enrollment in schools or more precisely the dropout rate among girls speaks of discrimination. The discrimination is deeply rooted. Even the professional connotations differ as per gender. The nurse word only reflects women. Secretary when applied as a woman connotes junior staff like stenographer. The power of decision consequently lies with males. The male dominant society knowingly and un-knowingly continues to behave in similar fashion. Teenage marriages exclusively harm the girls' health rather than boys. Violence against Women including sex selection is another manifestation of this inequality, used as a tool to reinforce norms and maintain this inequity in society.

Health Seeking Behavior

There appear to be gender differences in perceptions of distress and in patterns of health-care seeking among those suffering from mental health problems. Culturally driven timidity prohibits seeking treatment especially in reproductive and sexually transmitted infections. The reluctance from husband or in-laws to accompany the woman to health institution is very commonly observed among majority of homes.

Service Delivery Issues

The low detection and referral rates for communicable and non- communicable diseases in primary care settings may affect women disproportionately more than they affect men. This often happens with mental health problems.

Health Services Utilization

Generally it is assumed that in childhood immunization the discrimination is not observed. An analytical report of the three National Family Health Surveys have shown that girls were found to have significantly lower immunization coverage ($p<0.001$) than boys for almost all

primary vaccinations [19].

Traditionally medical colleges and health services department are teaching technical and managerial advantages of vasectomy over tubectomy since decades. Excepting during the era of National Emergency the female sterilization has remained the only procedure adopted by the couples. The latest available data for 2013-14 shows that about 3.62% were vasectomies. At national level for the nine months period from April 2014 to December 2014 the percentage of vasectomies was 2.17%. This is the contrast between teaching and acceptance by the community.

Health Response

In one writ petition against Union of India (209/2003) the applicant has very scathingly pointed out the quality of services provided. The applicant particularly has described the manner in which females undergoing sterilization operation are dealt without any respect to their dignity and privacy.

The girls and young women from different part of country are forced to indulge in commercial sex. The health sector is directly concerned with provision of services to avoid unwanted pregnancies, prevention of sexually transmitted infections and comprehensive abortion services. The present efforts are not adequate and are not functioning effectively.

Another totally different aspect pertaining to gender is provision of work place safety. A peculiar phenomenon of health sector is the huge magnitude of female work force. The highest number is of Auxiliary Nurse Midwives. She is posted in a sub-center which is a small village usually far away from her place of residence. She is in the tender age group and vulnerable to local politics, vandalism etc.

Implications:

Declining Sex Ratio

The discrimination has resulted in elimination of quite a few women from the community. The overall sex ratio is continuously declining excepting last two censuses. The main contribution to this increase is from number of senior single women. The other and more sensitive indicator is child sex ratio which is declining. This indicator points towards situation for last few years. The comparative figures of child sex ratio and overall sex ratio data in India are shown in Fig. 2 [20]. The data for child sex ratio is available from 1961 onwards. The graph clearly indicates that the situation worryingly deteriorating. There are only eight states/union territories which have shown a slight improvement, rest all states/union territories have witnessed a sharp decline. This doesn't reflect only the neglect of girl child but also includes sex selective elimination.Since 1980s this nonconformity to the natural male to female sex ratio has been noted and described by Indian philosopher and economist Nobel laureate Amartya Sen articulating a phrase by coining the two words, "missing women". The trio of son preference, acceptance of small family norm and easy availability and affordability of non-invasive selection and elimination techniques is responsible for this irreparable damage to the society.

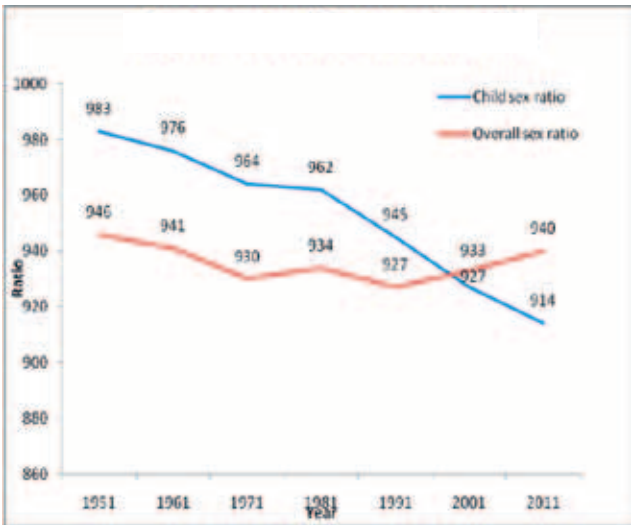

Fig. 2: Trend in Sex Ratio, India

Violence against Women

Although the targets in Goal three are pertaining to education, the third Millennium Development Goal in very assertive way states, "to promote gender equality and empower women". In the declaration on the elimination of violence against women, United Nations on 23 February, 1994 has defined violence against women as follows. Any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life.The violence may be domestic or at work place. Considering the magnitude of domestic violence against women, the Parliament of India has enacted 'Domestic Violence Act' in 2005. In the spectrum of the act, violence at work place is not covered.

Almost 40% of ever-married women have reported spousal physical, sexual or emotional violence in National Family Health Survey 3. All women are vulnerable to violence. However risk of violence is known to increase during pregnancy- with abdomen usually being targeted. The risk also increases when the woman is having some illness specially tuberculosis, STD or HIV or mental illness. In Indian context particularly if the woman is infertile or bearing only daughters she may be abandoned. Although these are precipitating factors for violence, the violence is known to increase the risk of depression, adverse pregnancy outcome, STD including HIV, alcohol use and most importantly injury or even murder [21].

The crime against women is increasing. In last five years excepting dowry deaths all crimes under Indian Penal Code have increased 14% to 101% [22]. The details are given in Fig.3. These are recorded incidences. The magnitude of unrecorded may be more than reported in bureau. After the Delhi incidence of rape India has become infamous for violence against women.

Fig.3: Crime against Women in India, 2013

Social Consequences of Illness

Many chronic illnesses like tuberculosis, leprosy have social stigma but when the patient is a woman it increase in geometric proportion. Women may face greater disability than men because of the higher prevalence of depressive and anxiety disorders.Depression could be as disabling or more disabling than several other chronic medical conditions in terms of social functioning, physical functioning, and role functioning and days spent in bed. Those with a physical condition as well as depressive symptoms are likely to be at high risk for disability. There are gender differences in this. In Indian community mentally challenged patients including schizophrenic if married, men are likely to be cared for and financially supported by their wives, while women are more likely to be deserted, abandoned or divorced by their husbands, and to have experienced physical abuse by their husbands prior to separation. Other conditions like infertility, having girls only also lead to abandonment, physical abuse and mental harassment.

References

1. Registrar Generaland Census Commissioner, India. Government of India, Ministry of Home Affairs. SRS statistic report 2013.
2. Registrar General and Census Commissioner, India. Government of India, Ministry of Home Affairs. Appendix_SRS Based Life Table 2009-13.
3. National Sample Survey Organization. Ministry of Statistics and Program Implementation Government of India. Morbidity, Health Care and the Condition of the Aged: NSS 60 th round (January – June 2004). March 2006.
4. Ngo ST, Steyn FJ, McCombe PA. Gender differences in autoimmune disease. *Frontiers in Neuroendocrinology* 2014; 35 (3): 347–336.
5. WHO Department of Gender, Women and Health. Gender and blindness; Gender and health information sheet. http://www.who.int/gender/documents/ blindness/ a85574/en/
6. Snow RC. Sex, Gender and Vulnerability. Research Paper (07-628); Population Studies Center. September 2007. Available on; http://www.psc.isr.umich.edu/pubs/pdf/ rr07-628.pdf.Accessed on 20th March 2013.
7. UNAIDS(2010). "Women, Girls, and HIV" UNAIDS Factsheet 10 (Report). Geneva: UNAIDS.
8. World Health Organization.Gender and women's mental health.Gender disparities and mental health: The Facts.
9. Mayra Buvinić, André Medici, Elisa Fernández, and Ana Cristina Torres.Gender Differentials in Health in Disease Control Priorities in Developing Countries.2nd edition.Jamison DT, Breman JG, Measham AR, et al., editors. Washington (DC): World Bank; 2006.
10. Balarajan YS, Fawzi WW, Subramanian SV.Changing patterns of social inequalities in anemia among women in India: cross-sectional study using nationally representative data. *BMJ Open* 2013; 19; 3(3). pii: e002233.
11. Malcolm Potts. *WHO* Chronicle 1986; 40: 175-183.
12. Mahmoud Fathalla, President of the International Federation of Gynecology and Obstetrics (FIGO), World Congress, Copenhagen 1997.
13. World Health Organization, 2014, Trends in Maternal Mortality: 1900 to 2013: Estimates by WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division.
14. World Health Organization, 2007, Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA, and The World Bank.
15. Registrar General, India New Delhi. Sample Registration System. Maternal Mortality in India: 1997-2003 Trends, Causes and Risk Factors.
16. Registrar General, India New Delhi. Sample Registration System.Maternal Mortality Ratio Bulletin 2011-13.http://www.censusindia.gov.in/vital_ statistics/mmr_bulletin_2011-13.pdf.
17. Indian Council of Medical Research. National in 2012. Center for Disease Informatics and Research; National Cancer Registry Programme. Three-Year Report of Population Base Cancer Registries 2009-2011. Bangalore, India February 2013.
18. International Agency for Research on cancer. Globocon 2012: Estimated Cancer Incidence, Mortality and Prevalence Worldwide. http://globocan.iarc.fr/old/ FactSheets/cancers/breast-new.asp.
19. Corsi DJ, Bassani DG, Kumar R, Awasthi S, Jotkar R, Kaur N, Jha P. Gender inequity and age-appropriate immunization coverage in India from 1992 to 2006. *BMC Int Health Hum Rights* 2009; 9 Suppl 1:S3.
20. Registrar General and Census Commissioner, India. Government of India, Ministry of Home Affairs. Census 2011.
21. World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. 2013.
22. Available on; http://apps.who.int/ iris/ bitstream/ 10665/ 85239/1/ 9789241564625_eng.pdf. Accessed on 23 March 2015.
23. National Crime Records Bureau, Ministry of Home Affairs, New Delhi. Crime against women. Available at http://ncrb.gov.in/. Accessed on 21 March 2015.

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