

Gender in the HLEG Report

Missed Opportunity

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Apart from referring to gender concerns in its chapters addressing critical areas of the healthcare system, the High Level Expert Group's report on Universal Health Coverage for India has a separate chapter on gender and health. While the report as a whole and this chapter make several sound suggestions, what comes through is that much more could have been done. In the absence of a gender and health analysis framework, the report tends to address gender issues in an ad hoc and uneven fashion.

The opinions expressed in this paper draw on research done by one of the authors for the WHO's "Gender, Women and Primary Health Care Renewal: A Discussion Paper" (2010).

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The report of the High Level Expert Group (HLEG) on Universal Health Coverage (UHC) for India deserves to be commended for putting gender firmly on the agenda of healthcare. In its definition of UHC, the report includes gender alongside income level, social status, caste and religion as attributes that could individually and in combination constitute barriers to equitable access to healthcare. Gender is recognised as a social determinant of health, but also receives special emphasis because "gender discrimination and gender insensitivity, if left unaddressed, will threaten the very framework and guiding principles of UHC for India" (HLEG 2011: 48). Accordingly, the report dedicates an entire chapter to gender and health besides referring to gender concerns in the other chapters. In addition, many of the report's excellent recommendations, aimed at inclusiveness, have been developed within an equity and rights framework and they also benefit those at a disadvantage because of gender.

Despite these and other strengths, there are crucial gaps in the gender issues related to UHC identified and highlighted in the HLEG report. In this paper, we first examine the recommendations made in the chapters addressing critical areas of the healthcare system from a gender perspective. That is, we examine whether and how the different roles of women and men and the unequal power relations

between them will affect the extent to which they will benefit from the recommendations towards achieving UHC.¹ We then focus on the chapter on gender and health, commenting on its content and recommendations.

Gender Issues in Critical Areas

The HLEG report opens with a chapter on the overall vision for UHC and is followed by six chapters, each of which is devoted to a critical area for action to enable India's health system to deliver care in an equitable manner to all. Detailed recommendations are made for each of the following areas.

- Health financing and financial protection;
- Health service norms;
- Human resources for health;
- Community participation and citizen engagement;
- Access to medicines, vaccines and technology;
- Management and institutional reforms.

The recommendations on health financing and financial protection focus on reducing out-of-pocket expenses while relying on tax-based revenue as the principal source of financing. If implemented, they will lower the financial barriers in the way of women-seeking healthcare. For instance, the availability of essential drugs free of cost will take a major financial burden off older women who suffer from chronic conditions. In general, such conditions affect more women than men. Though they have a higher life expectancy than men, most women are less likely to be covered by health insurance because of not having worked in the formal sector. Likewise, more investment in healthcare at the primary level will bring services closer

to women (and others) who find it difficult to travel or are unable to afford the costs of transportation.

An important factor that will influence the expenses that will still have to be borne by patients is the content of the National Health Package (NHP) because services not included in it will have to be paid for. The report says the NHP should “cover all common conditions and high-impact, cost-effective healthcare interventions for reducing health-related mortality and disability” (2011) but if it ultimately does not cover services that a significant proportion of women or men will need at different points in their life, they will remain beyond the reach of those who cannot pay for them. Much will depend on the extent to which the public and private health sectors actually make available the services listed in the NHP, failing which the population will once again have no recourse but to pay for them from other private-sector providers, formal or informal.

The financing recommendations do not make any reference to social protection health schemes targeting vulnerable groups of the population, which, according to the World Health Organisation (WHO), “would be needed in order to bridge the gaps in health status resulting from social and gender inequities” during the transition to UHC (2008: 33). In other words, social protection health schemes are needed as immediate measures in the short run to begin the process of closing the gender and social divides in health status as well as access to care.

The recommendations related to health-service norms could have better addressed issues of gender equity. A number of criteria have been outlined for determining the contents of the NHP, but gender-related ones are missing. One commonly used set of criteria for taking into consideration gender differentials in health needs is addressing conditions that occur exclusively in women and men as well as ailments that are more common to women, manifest differently in them and are more severe or have more serious consequences to them. It also includes illnesses that have different risk factors for women and men (PAHO 1997). The same can be extended to include

traditionally underserved groups such as transgendered people, those with different sexual orientations, older persons and adolescents. Although presented only as an indicative and illustrative list, a life cycle framework (as suggested in the gender and health chapter) could have been provided and the heavy slant towards a traditional maternal and child health (MCH) package could have been avoided.

Many non-financial barriers exist in access to health services that are rooted in gender-power inequalities between women and men, such as women’s lack of decision-making power on whether, when, where and for what to seek healthcare and restrictions on their mobility. These barriers can be mitigated to some extent by suitable organisation of health services and this could have been mentioned in the recommendations on health-service norms. For example, services available closer to home or the workplace and at times suitable to women or men are more likely to be utilised and could make a big difference to identification of morbidity and effective treatment and cure.

Another dimension is creating exclusive spaces and timings within service delivery settings for women, men and young people of both sexes to make services more “acceptable” to them. Integration of some services could enhance privacy and/or reduce stigma as, for example, when services for sexually transmitted infections (STI) or HIV/AIDS, abortions (especially medical ones) or infertility are made available at the primary care level as part of comprehensive sexual and reproductive healthcare. Horizontal integration of services across traditionally vertical programmes will be a further advance, such as, for example, the availability of directly observed treatment, short-course (DOTS) services for tuberculosis in the same facility as MCH care.

Equity in access to hospital beds for the rural population and the urban poor has been rightly emphasised in one recommendation. A similar emphasis is needed on beds for women (excluding maternity beds). According to anecdotal evidence, many hospitals have fewer beds for women than men when maternity beds are not considered.

The recommendation on quality assurance standards within health-service norms could have gone beyond Indian Public Health Standards (IPHS) to include a rights-based perspective on patient-provider interactions. The following are a few essential quality norms from a gender and rights perspective.

- No physical or verbal abuse of any patient by any member of the health team;
- Informed (and “understood”) consent for all procedures obtained from adult patients;
- No requirement for husband’s permission for procedures carried out on adult married women;
- No conditionalities imposed for provision of any services (for example, acceptance of contraception made a condition for providing abortion services);
- Visual and auditory privacy;
- Confidentiality;
- Non-discrimination on the basis of class, caste, gender, sexual orientation; and
- Sensitivity to the possibility that any woman examined may be experiencing gender-based violence and adopting a policy of upholding the woman’s safety above all else.

Human Resources Chapter

The chapter on human resources for health recommends the inclusion of social determinants and gender and equity issues in the curricula of medical professionals. It would be equally important to integrate gender and equity issues in the pre-service and in-service training curricula of all health workers such as nurses, auxiliary nurse midwives (ANMs) and the cadre of community health workers proposed by the HLEG. A recognition of gender inequalities within the health workforce is missing from the human resources chapter. These are, however, addressed to some extent in the chapter on gender and health.

Recommendations related to community participation and citizen engagement call for the inclusion of women’s groups in the proposed community health councils and in running people’s facilitation centres for redressing grievances. Both are welcome measures if implemented and could potentially draw attention to

issues involved in unpaid health and care work carried out in households, mostly by women.

The recommendations related to medicines, vaccines and technology are comprehensive and informed by equity considerations. The control of drug prices and the manufacture of vaccines and drugs within the country will benefit women for several reasons. For example, many have less access to or feel less entitled to financial resources but have to buy medicines for several years. Examples would be users of reversible contraceptive methods such as the oral pill and older women afflicted by chronic diseases. However, special attention must be paid to the different health needs of women and men across the life cycle when defining “essentiality” for the purpose of drug price control. An example is the female condom, which has the potential for saving women’s lives by preventing heterosexual transmission of HIV as well as preventing pregnancies, but is currently beyond the reach of most women because of its high cost.

The chapter on managerial and institutional reforms makes excellent recommendations on ensuring professional advancement, with a special focus on opportunities for ANMs and nurses. Yet, more could have been said on promoting the gender balance in leadership in academic medicine, public health and nursing through specific initiatives to nurture and mentor leadership capabilities. Further, specific recommendations could have been made for institutional changes in the health sector that would have supported the system-wide integration of a gender perspective. For instance, health officials could be made accountable for attention to gender equity in all policies and programmes.

It is disappointing to note that the recommendation on developing national health information technology makes no reference to the production of essential information for gender-sensitive policy-making and programming. The issue of data for addressing gender concerns is, however, brought up in the separate chapter on gender and health.

In short, the recommendations across different chapters of the HLEG report

address gender issues sporadically, without a systematic gender analysis framework that would have drawn attention to the many ways in which gender-based differences and inequalities affect specific aspects of the health system.²

Focus on Gender and Health

Ideally, the chapter on gender and health would have provided the background information necessary to understand the need for paying attention to the gender-based differences and inequalities that pose a challenge to achieving UHC. It would have consolidated and filled the gaps in the recommendations made in all the other chapters and added recommendations to cover the areas of gender-based disadvantages in healthcare not addressed in them. In its present format, the chapter stands unrelated to the other chapters. It does not effectively make the case for integrating gender issues across all dimensions of UHC and does not bridge the gender divide (some of which have been pointed out above) in the recommendations made in the other chapters. Nor is it an effective stand-alone chapter that comprehensively addresses all gender issues related to UHC.

In our view, one of the fundamental problems with the chapter is the absence of a gender and health analysis framework informing the conclusions presented. Attention to gender issues seems to be

often reduced to addressing the differential needs of different genders, arising out of biological as well as social differences. Even when political, economic, social and health system barriers are identified, these are not related to the unequal gender-power relations in society and in its various institutions.

The chapter begins with an inclusive definition of gender, going beyond the male-female binary to include other genders, which is admirable. However, given that there is very limited published “evidence” currently available on the different health needs, barriers to health-seeking and discriminatory treatment of other genders as well as the social and economic consequences of ill health among them, this addition remains a token gesture. The other genders also do not find a substantive place in any of the recommendations made in this or other chapters. Rather than make a token inclusion, it may have been better to acknowledge the limitations in data and at least examine gender inequalities across the male-female binary and the consequences of its intersections with other axes of structural inequalities such as caste, class and sexual orientation.

There is also a conflation of gender and sexual identities in the definition of gender. “A gendered perspective would thus take into account the health needs of all categories of sexual identity;

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heterosexual, homosexual, lesbian, gay, bisexual, 'queer', transgendered, transsexual, and asexual," says the report (2011: 297). We believe that the issue of discrimination on the basis of sexual orientation or identity merits independent examination as an axis of inequality that would be a barrier to UHC. Combining it with gender-based inequalities does not do justice to either – inequalities between women and men, and discrimination and disadvantages based on sexual orientation.

The core of the UHC scheme rightly sees health as a human right and the system as such is envisioned from a rights perspective. However, it is not clear whether sexual and reproductive rights are assumed to be an integral component of such a framework. The first section of the chapter, on the burden of disease, makes no link between the violation of sexual and/or reproductive rights of women, men, other genders and sexual minorities and disease burden. Vulnerable groups such as sex workers and people living with HIV/AIDS tend to disappear from the discussion in the absence of a sexual and reproductive rights framework.

After a sketchy section on the burden of disease that contains little information on other genders or diverse sexualities, the chapter moves on to establish the rationale for a gender perspective in UHC. It presents evidence on gender differentials in healthcare in no particular logical sequence. It would have been really useful if it had systematically addressed gender issues in the six critical areas discussed in the report and illustrated the imperative to incorporate a gender perspective, informed by a gender and health analysis framework. As such, it is not clear why some issues have been highlighted in the recommendations while others have not been.

Recommendations

The gender and health chapter makes four recommendations. The first is improving access to health services for women, girls and "other vulnerable genders". There is no mention of sexual identity or sexuality or the different health needs of men. Improved access is

to be achieved through a package of services that covers broad sexual and reproductive health services, critical mental health services, services to address gender-based violence and work-related health issues. There is also mention of locating health services in locations convenient to women and operating them at times suitable for them. Training health workers to be sensitive to the issues women and girls, and poor and marginalised communities face also find mention. The last presumably includes "other genders" and "diverse sexual identities" though it is not spelt out. One would have expected this recommendation to be tied to those on the contents of the NHP, which is to be available to all persons free of cost at the point of delivery.

The second recommendation is about recognising and strengthening the central role of women in healthcare provision in the formal and informal sectors. It calls for creating safe and secure working environments free of gender bias, while meeting the housing and childcare needs of women health workers. Ensuring that there is scope for re-entry to the workforce after a break for child-bearing, and accountability and redress mechanisms against sexual harassment in the workplace also figure under this recommendation. Improving the prospects for expanding career opportunities and representation in management positions is a sensible suggestion. A major proposal to ease the burden of home-based carers is creating community-based care programmes such as day care centres and facilities for palliative care, domiciliary care and ambulatory care. These are important and welcome measures that will definitely ease the burden of women health workers, formal and informal.

Building the capacity of the health system to recognise, measure, monitor and address gender concerns is addressed in the third recommendation. Information is vital for the formulation of appropriate policies and programmes, but the collection of sex and age disaggregated health data by all concerned, as outlined in the recommendation, will not be adequate to "address gender concerns". A reasonable amount of work is available on what constitutes gender-sensitive

health indicators (distinct from sex-disaggregated indicators) and how one would go about identifying a core set of indicators for a country that could be taken advantage of.³

The fourth recommendation calls for the empowerment of women, girls and other vulnerable genders, an essential condition for realising health rights. Empowerment is a complex process requiring changes on many fronts and the two rather disparate strategies outlined under this recommendation – sensitising young people on health, gender power equations and their health consequences; and removing conditionalities from all health programmes – are not particularly useful.

In conclusion, although brilliant in parts, gender issues have been addressed in an ad hoc and uneven fashion in the HLEG report on UHC. The recommendations do not in most instances provide specific and clear guidelines for correcting gender-based inequalities in access to healthcare. This is unfortunate and a major missed opportunity. It is also unexpected given that there was considerable expertise on gender among the HLEG members. The only plausible explanation for this is that the report is the result of a negotiated consensus among disparate positions, which may have neutralised the significant representation of gender experts in the group.

NOTES

- 1 We acknowledge the importance of going beyond the binary categorisation of male and female in gender analysis but do not have the expertise to bring in the concerns of other vulnerable genders into this analysis.
- 2 For example, the WHO gender and health Analysis framework calls attention to differentials in health needs in terms of incidence, prevalence, risk factors, severity and prognosis of health conditions; in health-seeking behaviour; in health system responsiveness; and in the social and economic consequences of ill-health.
- 3 See, for example, papers in the supplement on gender-sensitive indicators in the *International Journal of Public Health* (2007), Vol 52.

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