GENDER BUDGETING[1]

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The Mid-Term Appraisal of the Tenth Plan notes that the reality is that women still remain largely untouched by Gender-just and Gender Sensitive Budgets as well as the Women's Component Plan. Gender budgets are not separate budgets for men and women but are just a tool that can be used to ensure that the aggregate national or departmental budget is gender sensitive. The purpose of Gender Budgeting is to achieve gender-just allocations and outcomes in all sectors and Ministries. This requires identification of needs and priorities of women, especially those who are poor, examination of existing policies, programmes and schemes to determine whether or not they meet these priority needs; corrective reprioritization of budgetary allocations so that they are adequate for meeting those needs; and taking requisite follow-up actions to ensure that desired outcomes are attained.

In other words, this tool can be used to address issues such as increased feminization of poverty, exploitation of women in low paid, arduous, insecure jobs; persistently high IMR, MMR, morbidity, anaemia and malnutrition due to lack of access to nutrition and quality healthcare. It should be used to correct gender gaps in literacy and education, wage differentials between men and women, violence against women, trafficking of women, bias in the female-male ratio, lack of access to water and drinking water, statistical invisibility of women's work and providing access to work. These gender issues need to be flagged and translated into the policies, programmes and schemes of individual Ministries and Departments.

WOMEN'S PRIORITIES IN BUDGET ALLOCATION

What are women's priorities in household budget allocation? In any budget, however small, women give the highest priority to nutritious food for the family. The objective is good health. Purchasing power is needed to buy food. Purchasing power depends primarily on availability of work or employment opportunities for the able bodied and fair remuneration or wage or salaries received for work. Despite plans and poverty alleviation strategies, we have 301.7 million people in poverty, many of whom do not get two square meals a day. In 2004–05, 27.5 per cent of India's population was below the poverty line based on the same method that was used by the NSS for 1993–94 quinquennial estimates.

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1. This paper is based on research conducted for the National Commission for Women on 'The Budget: A Gender and Poverty Sensitive Perspective', New Delhi, 2003; for a UNIFEM-IIPA study entitled 'The Impact of HIV/AIDS on Women Care Givers in Situations of Poverty: Policy Issues', Aasha Kapur Mehta and Sreoshi Gupta, UNIFEM and IIPA, New Delhi, 2006; ongoing research on chronic poverty; and two workshops conducted by MWCD, IFES and IIPA on Gender Budgeting for Gender Budgeting Cells of the Ministries of the Government of India in October 2006 and January, 2007.

Therefore if we determine budget priorities at the macro national level on the basis of what are the micro household priorities in the budget allocation, or if we build budget priorities at the macro national level from a gender and poverty sensitive lens, then they must include poverty reduction, opportunities for employment for all able bodied, eradication of hunger, access to safe drinking water, access to quality and affordable health care, correcting the bias in the female-male ratio and safety nets for the old who are poor, and for the poor who are disabled.

THE CONTEXT: POVERTY AND ILL HEALTH

Ill health creates immense stress even among those who are financially secure. The National Rural Health Mission notes that 25 per cent of Indians fall below the poverty line because of hospital expenses (GoI, 2005). Hospitalized Indians spend on an average 58 per cent of their total annual expenditure on medical care. Most do not have insurance and borrow heavily or sell assets to cover expenses. Any chronic illness such as TB, cancer or HIV is a shock that can exacerbate the distress of those who are poor and drive many of the non-poor below the poverty line.

NSS data for 1986–87 (42nd round) and 1995–96 (52nd round) show that over this period, the proportion of ailing persons based on 30-day recall, increased from 6.4 per cent to 8.6 per cent in rural and 3.1 per cent to 8.4 per cent in urban areas. The morbidity estimates from the 60th round of NSS (January to June 2004) showed a significant increase in the proportion of ailing persons. The estimates based on 15-day recall increased from 5.5 per cent in 1986–87 to 8.8 per cent in 2004 in rural areas and 5.4 per cent to 9.9 per cent in urban areas (GoI, 2006). The proportions were marginally higher among the women as compared to men, both in the rural and urban areas.

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Micro-studies reflect far higher estimates of morbidity. For instance, the CMDR survey showed that morbidity was around 27 per cent in Maharashtra, 18 per cent in Karnataka and 27 per cent in Orissa (Panchamukhi and Puttaswamaiah, 2004). Further, all three States had a high incidence of communicable diseases, possibly due to poverty and malnutrition and environmental factors such as poor sanitation and the lack of safe drinking water.

While poverty and ill health affect both men and women, the problems get compounded for women for many reasons. Firstly, women's lack of access to and control over resources and decision making lead to lower levels of access to healthcare services for them. 'While men have higher rates of disease morbidity for many major diseases, including TB and malaria, a larger percentage of women die due to the fact that they are often only brought in for diagnosis and treatment at severe stages of illness, when treatment is less effective' (CARE, 2006). Secondly, when any member of the family falls ill, women routinely add the task of providing care to their other tasks, thereby adding to their unrecognized work burden, which leads to their higher levels of tiredness and morbidity. Thirdly, 'more than half of the female population in India suffers from anaemia due to lack of nutrition' (Ibid) Since they are the last to eat in many homes, where there is inadequate availability of food, this cultural norm often leads to intra-household discrimination in access to food and nutrition (Sudarshan and Bhattacharya, 2004).

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The National Health Policy (2002) includes a scathing criticism of the existing public health infrastructure, insufficient funds, inadequate medical and para-medical personnel, negligible availability of consumables, obsolete and unusable equipment, dilapidated buildings, over-crowding, steep deterioration in the quality of the services. Mortality and morbidity rates are exceptionally high, despite the fact that we

can successfully and significantly reduce their incidence. The financial allocations to the health sector are very inadequate and need to be increased significantly and reprioritized based on gender responsive budgeting.

HIV/AIDS: STATUS, ALLOCATIONS AND NEEDS

UNAIDS estimated that as many as 5.7 million Indians were living with HIV at the end of 2005 (http://www.unaids.org/en/Regions_Countries/Countries/india.asp). NACO estimated that there were 5.134 million HIV positive persons in India in 2004. While both estimates were based on sentinel surveillance surveys and give information on trends, UNAIDS attributes the difference to their inclusion of data on people over the age of 49 years by UNAIDS (*Business Standard*, 2007). National Family Health Survey's recent estimates are that India has 2.47 million HIV cases. However, the methodology used by the NFHS is different and the estimates are not comparable. The reduction in the numbers could be due to a combination of factors that include stabilization of the epidemic as well as death of many of those suffering from AIDS.

A cumulative 1,24,995 persons suffered from AIDS from 1986 to August 2006. Six States, Andhra Pradesh, Tamil Nadu, Maharashtra, Karnataka, Manipur and Nagaland have generalized epidemics with HIV prevalence rate of above one per cent among pregnant women. More than 50 per cent of the CSWs in urban southern States are infected. 6,00,000 PLWHAs are in need of antiretroviral therapy (http://www.unaids.org/en/Regions_Countries/Countries/india.asp). Only around 55,000 people are able to access ARVs through government centres and 15,000 patients through private clinics. Less than 15 per cent of Indians with HIV are able to get access to ARVs, while the comparative estimates of access are 32 per cent for South Africa, 44 per cent for Kenya and 26 per cent for Nigeria (http://www.pkids.org/hivnews/?p=293). Regardless of numbers, the fact is that most of those who are chronically ill, do not have insurance and lack the means for meeting medical expenses. Public provisioning for health care is abysmal and needs urgent attention.

There is a mismatch between the availability of funds for tackling HIV/AIDS and its translation into outcomes that are needed by those infected and affected by HIV/AIDS. For instance the World Bank reports that

> India receives technical assistance and funding from a variety of UN partners and bilateral donors. USAID has committed more than US$70 million since 1992, CIDA US$11 million, and DFID close to US$200 million. The number of major financers and the amount of funding available has increased significantly in the last year. Since 2004, the Gates Foundation has pledged US$200 million for the next five years, the Global Fund has approved US$54 million for HIV/AIDS for projects in rounds two, three and four. DFID has also increased its financing and is considering the inclusion of additional states. Other more recent donors include DANIDA, SIDA, the Clinton Foundation and the European Union (World Bank, n.d.).

While funds are available for HIV/AIDS, yet despite this, many of those who are affected and infected by HIV, do not have access to these funds and instead incur severe debt and penury due to medical and other expenditure. The burden of ill-health and care for women and the poor remains huge as can be seen from numerous case studies. Clearly, funds that are available need to be re-prioritized and better targeted so that the needs of positive persons are met and this gets reflected in better outcomes.

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PROVISIONING OF MEDICAL CARE AND INFORMATION NEEDS REGARDING MEDICATION

To enable the PLWHA to lead productive lives and to reduce exploitation and relieve the workload on care givers:

- Universal coverage of those needing antireterovirals (ARV) and continuity of access to the appropriate drugs and line of treatment is urgently required.
- Funds must be allocated urgently to ensure access to pre and post test counselling, medical care, treatment, diagnostics, monitoring CD-4 counts etc. After a person is started on ARV, CD-4 counts change and monitoring this is important, though expensive.
- Doctors have long queues of patients demanding attention. They do not have the time to explain that a particular medicine has to be taken every day, or why a patient cannot afford to miss one day's medication. Information needs to be patiently communicated regarding the importance of regularity in taking medicines, adherence and drinking boiled water to avoid diarrhoea. Hence representatives of Positive People's Networks should be present to communicate this when PLWHA are started on ARV.
- Provision of accurate information regarding the treatment, care and costs will go a long way towards reducing exploitation and unnecessary expenditure. Therefore, information must be widely publicized regarding HIV/AIDS, prevention, use of condoms, availability of testing facilities and costs in the public and private sectors, opportunistic illness, when and what medication is needed, the effect of indiscriminate medication, the medication regimen, the cost of medication, when antibiotics need to be used, the importance of adherence to prevent resistance and of avoiding indiscriminate use of antibiotics.
- The training and infrastructure needs of health care providers at all levels need to be identified and met. Doctors must be made aware of the latest developments in medicine and should not prescribe wrong medicines or experiment on patients.
- Doctors, functional testing equipment and an ambulance must be available in all PHCs and peripheral hospitals if they are to respond to patient needs. There must be enough doctors and an ambulance at all times so that patients can be rushed to the larger hospitals in case of need. Doctors stress the need for an ambulance and functional x-ray, sonography, ECG and CD-4 machines that are maintained and available for 24 hours each day.
- In government hospitals the schedules need to be changed to include the latest antibiotics that can be used, depending on the discretion of the doctor, if bacteria do not respond to treatment. The newer medication may be more expensive but it should be available for serious patients. If it is not in the schedule, a series of administrative approvals become necessary.
- Increased access to community care homes to enable support in times of difficulty and opportunistic illnesses, to reduce the burden of care on home based care givers or when such support is not available.

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When immunity declines, the person cannot tolerate diarrhoea-causing pathogens. In slums, diarrhoea and other stomach related problems are frequent, as is TB, as water is not available, is not safe, people do not understand the importance of boiling water. Therefore, give priority to access to safe drinking water in the home. Community bathroom facilities are available at a distance and these are dirty. Positive CSWs and other poverty stricken homeless persons suffer extreme hardship due to lack of access to toilet facilities and having to pay for their use. Those who live in slums or on footpaths must be provided access to clean toilets and bathing facilities. Therefore plan for access to public Indian style toilets at regular intervals (without charging user fees).

ATTITUDE OF HEALTH CARE PROVIDERS

The attitude of health care providers needs to change. Behavioural and attitudinal change at all levels is an important intervention and can be done through training,

sensitization workshops and follow up. Bed availability should be displayed in all hospitals so that this is not used as an excuse to deny services to the HIV+ patient. Basic knowledge and skills about the kind of care and how to administer the same, kind of nutrition required by HIV+ persons, importance of hygiene and counselling services are essential.

ACCESS TO CLEAN TOILETS AND WATER

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ACCESS TO WORK, SKILLS AND SOCIAL PROTECTION MECHANISMS

The major impact of HIV/AIDS on almost all the affected and infected women interviewed was that of financial deprivation due to the loss of income earning opportunities for the spouse on the one hand,worsened by expenditure and debt due to lack of access to quality public provisioned medical care, on the other.

The need for skills, skilled work and links with employment of IGPs emerged as critical. This is especially important for young widows to enable them to live in dignity and not fall prey to commercial sex work for survival. To break the cycle of poverty, gender inequality and vulnerability to HIV transmission, provide women with work related skills. There is an urgent need to provide access to social safety nets and link the poor with employment generating projects, networks and support groups.

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GENDER BUDGET FOR HEALTH

In view of the above, how do we prepare a Gender Budget that meets the health needs of women affected and infected with HIV? Clearly we have to re-prioritize expenditure so as to meet the long list of needs of women and men affected and infected with HIV that have been specified above. Only when these needs are met and gaps between needs provisioning are bridged, will the results get reflected in outcomes. While needs have been outlined specifically in the context of HIV/AIDS, the rationale applies to any chronic illness. The basic requirement is that of universal and mandatory access to quality preventive and curative treatment that is provided by the State, in rural and urban areas. This in turn will require that we strengthen *all* Primary Health Centres, Peripheral Hospitals, Community Health Centres and Public Hospitals to ensure access to reliable and quality medical care.

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