

**Gender Responsive Budgeting:  
Issues related to the Health Sector in  
Punjab**

**Sponsored by  
Government of Punjab and UNDP**

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# **Gender Responsive Budgeting: Issues related to the Health Sector in Punjab<sup>1</sup>**

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## **I. Introduction: What is Gender Responsive Budgeting?**

The Budget is not just about where money comes from and what it gets spent on. It is an instrument for fulfilling the obligations of the state and a political statement of the priorities set by the Government in allocating resources.

Gender Responsive Budgets are not separate budgets for women or for men. The purpose is to use Gender Responsive Budgeting as a means to review and monitor expenditure, public service delivery and taxation from a gender perspective.<sup>2</sup> It is a tool that can be used to ensure that the aggregate national or state or sector or departmental or programme or corporate or any budget is gender sensitive. It is an approach to developing plans in a participatory way, based on identifying priority needs of women as well as men and not just of those with voice.

The purpose of Gender Responsive Budgeting is to achieve gender-just allocations and outcomes of all public expenditure. This requires identifying the needs and priorities of women, especially those who are poor; determining whether or not these needs are met; reprioritising budgetary allocations so that they are adequate for meeting those needs; and taking requisite follow-up actions to ensure that desired outcomes are attained.<sup>3</sup>

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<sup>1</sup> Gratefully acknowledged are the Planning and Health Departments, Government of Punjab and UNDP for entrusting me with this significant task despite severe data constraints; IIPA for providing time and support for it; Economic Adviser, MWCD, Lawyers Collective and CBGA for some of the inputs regarding domestic violence; research assistance provided by Sanjay Pratap and typing of some of the tables by Sonia Bajaj and Padma Bhambani.

<sup>2</sup> Simel Esim, 2000. Gender Sensitive Budget Initiatives for Latin American and the Caribbean: A Tool For Improving Accountability and Achieving Effective Policy Implementation. *United Nations Development Fund for Women*, February. (<http://www.hsph.harvard.edu/Organizations/healthnet/gender/docs/esim.htm>).

<sup>3</sup> Aasha Kapur Mehta, (2007). Gender Budgeting, Alternative Economic Survey, Daanish Books, Delhi.

This Report seeks to explain what is Gender Responsive Budgeting and places it in the context of the fact that the onset of a chronic illness such as TB, cancer or HIV is a shock that can exacerbate the distress of those who are poor (especially women) and drive many of the non-poor below the poverty line. While poverty and ill health affect both men and women, the problems get compounded for women. Public provisioning of health care and universal access to it are critical to reducing entry into poverty and alleviating suffering. Section II describes women's priorities in allocating the household budget given a budget constraint and explains that if national and state budgetary priorities are determined on the basis of micro household priorities then they would necessarily prioritise access to health care that is of high quality. Section III outlines some of the biological and gender based differentials in the context of health, the many manifestations of gender bias in provisioning of health care. Sections IV and V analyse the comparative expenditure on health in budgets and plans and shortfalls against population norms for Community Health Centres (CHCs) and Primary Health Centres (PHCs) and medical personnel. Section VI and VII analyse the state of maternal and child health and disease burden in the context of gender while section VIII is devoted to highlighting the importance of viewing domestic violence as a public health issue and putting systems and budgets in place to respond to it effectively. Section IX concludes the Report.

### **The Context: Poverty and Ill Health**

The strong links between ill-health and poverty are now well established.<sup>4</sup> The National Rural Health Mission<sup>5</sup> notes that 25 per cent of Indians fall below the poverty line because of hospital expenses. 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. Ill health creates immense stress even among those who are financially secure. Any chronic illness such as TB, cancer or HIV is a shock that can exacerbate the distress of those who are poor (especially women) and drive many of the non-poor below the

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<sup>4</sup> Mehta, Aasha Kapur, Andrew Shepherd, Shashanka Bhide, Amita Shah and Anand Kumar India Chronic Poverty Report: Towards Solutions and New Compacts in a Dynamic Context, CPRC and IIPA, New Delhi, 2011.

<sup>5</sup> Government of India, National Rural Health Mission Document 2005-2012.

poverty line. Public provisioning of health care and universal access to it are critical to reducing entry into poverty and alleviating suffering.

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% to 8.6% in rural and 3.1% to 8.4% 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% in 1986-87 to 8.8% in 2004 in rural areas and 5.4% to 9.9% in urban areas.<sup>6</sup> The proportions were marginally higher among the women as compared to men both in the rural and urban areas. Micro-studies reflect far higher estimates of morbidity. For instance, the CMDR<sup>7</sup> survey showed that morbidity was around 27 percent in Maharashtra, 18% in Karnataka and 27% in Orissa. 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 health care 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."<sup>8</sup> 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 unrecognised 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."<sup>9</sup> Since they are the last to

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<sup>6</sup> Government of India Press Note dated 16 March 2006.

<sup>7</sup> Panchamukhi, P. R. and Puttaswamaiah, S. (2004). 'Morbidity Status, Utilization and Cost of Treatment: A Comparative Study in the Selected States', Centre for Multi-Disciplinary Development Research, Dharwad.

<sup>8</sup> Women's Empowerment for Better Health Outcomes (2006). CARE, New Delhi.

<sup>9</sup> CARE 2006 *ibid*.

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.<sup>10</sup>

The National Health Policy (2002) makes scathing criticism of existing public health infrastructure, insufficient funds, inadequate medical and para-medical personnel, negligible availability of consumables, obsolete and unusable equipment, dilapidated buildings, overcrowding and 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. Gender responsive budgeting requires recognition of the fact that the financial allocations to the health sector are very inadequate and follow up action to reprioritise allocations in the Central and State budgets so that funds for the health sector are increased significantly.

## **II. Gender Responsive Budgeting at Micro and Macro Levels<sup>11</sup>**

### **What are women's priorities in allocating the Household Budget given a Budget Constraint: Gender Responsive Budgeting at the Micro or Household level?**

The overarching goal for any family is for all members of the family to live long, healthy and productive lives. Routinely, when women decide how to spend the household budget, however small or large this budget may be, they give the highest priority to providing nutritious food for the family; health care for family members who are ill; expenditure on education and skills for children; followed by expenditure on necessary clothing, transport etc. Purchasing the essential quantities of food and other necessities requires access to money or purchasing power. This in turn depends on earned income or borrowing or wealth.

In theory, income is a function of returns to the factors of production, land, labour, capital and entrepreneurship or in other words, rent, interest on savings, dividends, profits, etc.

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<sup>10</sup> Ratna M. Sudarshan and Rina Bhattacharya (2004). Chronic Poverty and Gendered Patterns of Intra-Household Resource Allocation: A case study from East Delhi, CPRC-IIPA Working Paper 12, IIPA, New Delhi.

<sup>11</sup> This section and the one that follow it are based on Aasha Kapur Mehta., Samik Chowdhury, Subhamoy Baishya (2004). The Budget: A Gender and Poverty Sensitive Perspective, National Commission for Women: New Delhi.



However, in practice, poverty levels are extremely high and the income earned by most Indians depends primarily on the availability of work for the able bodied and remuneration received for work.

Good health and low mortality rates depend on a large number of factors that include the consumption of nutritious food; access to safe drinking water for drinking, cooking and washing; safe disposal of sewage to ensure no contamination of drinking water sources and spread of disease; reduction in levels of drudgery in work; and access to inexpensive but quality medical care and medication in times of ill health.

### **Budget priorities at the Macro or National Level viewed through a Gender and Poverty Sensitive Lens given a Budget Constraint: Women's Priorities in Budget Allocation**

Equal rights for men and women are embedded in India's Constitution. Women constitute almost 50 per cent of the population and as equal citizens, women have a right to stake a claim to their entitlements under all categories of public spending and not just token women's programmes.

As described above, in any budget, however small, women (and men) give the highest priority to long, healthy and productive lives for all family members. Since women are usually charged with the responsibility of preparing food for the family they need money to buy food. As described above, for most Indians, earnings depend primarily on availability of work or employment opportunities for the able bodied and remuneration or wage or salary for work. Therefore if we determine budget priorities at the **macro** or national/ state level on the basis of micro household priorities in budget allocation, or if we build macro budget priorities from a gender and poverty sensitive lens, then we must prioritise:

- the eradication of hunger and poverty,
- opportunities for "an adequate means of livelihood" through work for all those who are able bodied,
- **access to health care that is of high quality,**
- access to safe drinking water,
- safety nets for the old who are poor and for the poor who are disabled,
- access to education and skills and
- correcting the statistical invisibility of the paid and unpaid work contributed by women that contributes significantly to Gross Domestic Product.

The Eleventh Plan notes that “assuring a minimal level of health care to the population is a critical constituent of the development process.” One objective of the Eleventh Five Year Plan is “to achieve good health for people, especially the poor and the underprivileged” (Vol II page 57). The Plan notes that while considerable achievements have been made, problems abound. It draws attention to the effect of malnutrition, unacceptable levels of suffering and mortality due to new diseases that are emerging and continuing and new threats posed by the existing ones. Further, the Eleventh Plan commits to giving “special attention to the health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled, and primitive tribal groups” and views gender as the cross-cutting theme across all schemes (Vol II page 58).

Some of the time bound goals for Punjab that pertain to health are listed in Table 1.

**Table 1: Some of the Time-Bound Goals pertaining to Health to be achieved in the Eleventh Five Year Plan in Punjab:**

<b>Target</b>	<b>Punjab</b>	<b>Achievement</b>
• Reducing Maternal Mortality Ratio (MMR) to	From 1.78 to 0.59	1.92 in 2004-06
• Reducing Infant Mortality Rate (IMR) to	From 45 to 22	41 in SRS 2008
• Reducing Total Fertility Rate (TFR) to	From 2.4 to 2.1	Achieved 2.1
• Providing clean drinking water for all by 2009 and ensuring no slip-backs.		
• Reducing malnutrition among children of age group 0–3 to half its present level.	From 28.7 to 14.4	
• Reducing anaemia among women and girls by 50%.	From 41.4 to 28.7	
• Raising the sex ratio for age group 0–6 to	From 798 to 805	838 in SRS 2008

Human and gender development indicators are among the tools that have been used to capture improvement in human well-being more reliably than per capita income. The Human Development Index (HDI) introduced by UNDP in 1990 is a simple average of three dimension indices that measure average achievements in a country with regard to ‘A long and healthy life’, as measured by life expectancy at birth; ‘Knowledge’, as measured by the adult literacy rate and the combined primary, secondary and tertiary gross enrolment ratio; and ‘A decent standard of living’, as measured by estimated earned income in Purchasing Power Parity (PPP) US\$. The GDI adjusts the average achievement in the same three

dimensions that are captured in the HDI, to account for inequalities between men and women.

The Punjab Human Development Report ranks the districts of Punjab according to performance based on these three indicators.

**Table 2: HDI and GDI for the Districts in Punjab**

Districts	Overall		Rank		HDI Rank minus GDI Rank	HDI-GDI Score Difference
	HDI	GDI	HDI	GDI		
Amristsar	0.700	0.544	9	17	-8	0.156
Bathinda	0.674	0.625	14	7	7	0.049
F.G. Sahib	0.740	0.556	3	16	-13	0.184
Faridkot	0.698	0.643	10	4	6	0.055
Firozpur	0.689	0.643	12	4	8	0.046
Gurdaspur	0.723	0.565	4	15	-11	0.158
Hoshiarpur	0.718	0.645	5	3	2	0.073
Jalandhar	0.708	0.632	6	6	0	0.076
Kapurthala	0.707	0.652	8	2	5	0.055
Ludhiana	0.761	0.619	1	9	-8	0.142
Mansa	0.633	0.586	17	13	4	0.047
Monga	0.683	0.607	13	10	3	0.076
Muktsar	0.651	0.606	16	11	5	0.045
Nawanshehar	0.707	0.623	7	8	-1	0.084
Patiala	0.697	0.600	11	12	-1	0.097
Rup Nagar	0.751	0.669	2	1	1	0.082
Sangrur	0.654	0.575	15	14	1	0.079
<b>Punjab</b>	<b>0.667</b>	<b>0.614</b>				

Source:- Punjab Human Development Report

HDI and GDI scores, ranks and differentials presented in Table 2 show that Punjab had a score of 0.667 on HDI and a significantly lower score of 0.614 on GDI. As many as nine districts of Punjab, i.e., Ludhiana, Rup Nagar, Fatehgarh Sahib, Gurdaspur, Hoshiarpur, Jalandhar, Kapurthala, Nawanshehar and Amristsar, achieved HDI scores above 0.700. The highest value of HDI is scored by Ludhiana at 0.761. However, the highest GDI score was considerably lower at 0.669. The 5 best performing districts on GDI in Punjab are Rup Nagar, Kapurthala, Hoshiarpur, Faridkot and Firozpur while the 5 worst performing districts

on GDI are Amritsar, Fatehgarh Sahib, Gurdaspur, Sangrur and Mansa. The difference between HDI and GDI scores is highest for Fatehgarh Sahib (0.184), Gurdaspur (0.158), Amritsar (0.156) and Ludhiana (0.142) reflecting high disparities. This is also reflected in the loss of rank based on scores estimated for HDI and GDI. This is largest for Fatehgarh Sahib, which lost 13 ranks; followed by Gurdaspur with 11 ranks and Ludhiana and Amritsar with a loss of 7 ranks each. The largest gainer in rank between HDI and GDI is Firozpur with a gain of 8 positions.

### **III. Why Gender Responsive Budgeting in Health?**

We are born male or female and there are biological differences between males and females. Sex is therefore a “given” at the time of birth. However, socio-cultural behavior patterns, roles, responsibilities, expectations and access to and control over resources add layers to these biological differences. These “gender” based layers may differ across space and time. For instance, in several developed countries, each person – whether male or female - is expected to cook meals for him or herself and contribute to household chores such as cooking, cleaning and washing dishes. However, in India, in most households, gender roles lead to the expectation that women will take responsibility for what are known as the three Cs or cooking, cleaning and care. Verdonk et al<sup>12</sup> explain this as:

‘Sex’ refers to biological differences between men and women, i.e. chromosomes, internal and external sex organs and secondary sex characteristics as well as hormonal makeup. ‘Gender’ refers to how differences between men and women are constructed in different cultures.

While both cervical cancer and injuries inflicted by domestic violence are health conditions and need medical attention, occurrence of cervical cancer among women is based on sex or biology while injuries resulting from domestic violence are a manifestation of unequal gender relations.

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<sup>12</sup> Petra Verdonk, Yvonne W. M. Benschop, Hanneke C. J. M. de Haes, Toine L. M. Lagro-Janssen, From gender bias to gender awareness in medical education, *Advances in Health Science Education* (2009) 14:135–152

There are many manifestations of gender bias in the field of health. It is argued that women's health issues in domains other than reproduction "have been overlooked" (Verdonk et al *ibid*). For instance, "in clinical studies, female patients have been excluded for well-established reasons..." These include, apart from other factors, the "confounding effects of female menstrual cycle on test results, thereby increasing complexity and costs of research." However, the assumption that "expected physiological research findings conducted in male populations (can be extrapolated) to female patients" may lead to provision of medication "inadequately tested in women subjects." Further, "women may respond differently to drugs" as is the case in coronary heart disease (CHD) "in which an abundance of research has demonstrated differences between men and women." Citing Mosca et al. (2007) they point out that in 2004, the American Heart Association (AHA) published a first evidence-based guideline for the prevention of heart disease in women. Citing Rosser (1994) they highlight the existence of male bias in determining what is studied, methods used, analysis and conclusions drawn from data and illustrate this by pointing out that a larger body of knowledge exists in traditionally men's diseases such as coronary heart disease than in traditional women's diseases such as rheumatism. Further, "disease occurring more often in women is also considered less important."

Relegating women's health issues to reproductive health confirms "the social construction of women as mothers and wives" (Verdonk et al *ibid* citing Davis 1988; Nicolette and Jacobs 2000 and Searle 1998). Additionally, limiting reproductive health to women's health has led to "gaps in evidence-based knowledge on men's reproductive health problems." While heart disease, lung cancer, depression and abuse are dominant factors causing ill health among women, these topics "are not covered well by general medical journals" (Clark et al. 2002 cited in Verdonk et al 2009). In the context of mental health, "men may present depressive symptoms differently—or not present their depressive symptoms—and may mask a depression with alcohol abuse."

Box 1: Sex-related and Gender-related Differences Between Men and Women that Make a Difference in Women's Health.

### **Sex-related Differences**

- Women tend to wake up from anesthesia more quickly than men
- Some pain medications, known as kappa-opiates, are far more effective in relieving pain in women than in men.
- Women are more likely than men to suffer a second heart attack within one year of their first heart attack.
- The same drug can cause different reactions and different side effects in women and men - even common drugs like antihistamines and antibiotics.
- Women have stronger immune systems to protect them from disease.
- Women are more likely to get autoimmune diseases (diseases where the body attacks its own tissues) such as rheumatoid arthritis, lupus, scleroderma and multiple sclerosis.
- During unprotected intercourse with an infected partner, women are 2 times more likely than men to contract a sexually transmitted disease and 10 times more likely to contract HIV.
- Depression is 2-3 times more common in women than in men, in part because women's brains make less of the hormone serotonin.
- After menopause women lose more bone than men, which is why 80 percent of people with osteoporosis are women.

### **Gender-related Differences**

- Men have a greater propensity for risk-taking behaviours that may have serious and lethal consequences.
- Women and men do not receive the same (or similar) care, even for the same conditions. In the US women are less likely to receive high-tech services, and tend to receive less aggressive care for conditions such as heart disease and cancer
- Stress levels among women have been on the rise
- Depression is far more common in women.
- Violence is considered to be a major public health issue. Women are significantly more likely to be victims of sexual assault.
- It is estimated that women constitute 80% of those who provide care, whether or not that care is paid, and whether it is provided in institutions or at home.
- Poverty, a key determinant of health and longevity, is more common in women.

Source: Based on Karen Grant, GBA: Beyond the Red Queen Syndrome. Presentation at the GBA Fair Ottawa Congress Centre, January 31, 2002

Hence, the issues that need attention are that there are biological differences in the reactions of men and women to medication, anesthesia, and antibiotics and in their immunity to disease. Women are more susceptible to autoimmune conditions such as rheumatoid arthritis, lupus, scleroderma and multiple sclerosis; likelihood of contracting sexually transmitted disease and HIV during unprotected intercourse with an infected partner; depression (due to lower production of the hormone serotonin in women); and osteoporosis (caused by loss of bone after menopause) etc. Additionally, women and men do not receive the same care, even

for the same conditions; depression is more common in women; violence is a major public health issue and women are significantly more likely to be victims of sexual assault; and society demands unpaid care work from women within the home.

In Punjab, alcohol and substance abuse is a health condition and may mask depression among men and the domestic violence is a public health issue that needs attention.

In view of the sex and gender-related issues relevant to health outlined above, Gender Responsive Budgeting requires:

- Identification of the existing bias in medical education, medical research, attitude of care providers and health service provisioning;
- corrective action to remove these biases in medical education, medical research and attitude of care providers at all levels;
- provisioning for health care based on understanding of differences between men and women in disease burden and needs;
- explicit integration of gender equity in policies and programmes pertaining to health care;
- allocation of adequate budgets to deliver equitable health care of high quality.

### **III.1. Sex Ratio or Female – Male Ratio**

Bias in the sex ratio or female male ratio reflects poor health and survival of girls and women and is the most serious form of gender discrimination. The problem of ‘missing women’ and declining female-male sex-ratios is well documented. Availability of ultrasound technology that enables sex selection combined with strong son preference has led to “second trimester abortions that can carry significant risks for the pregnant woman” (Sen and Ostlin<sup>13</sup>). Gender bias can have intergenerational health related consequences “starting with maternal under-nutrition leading to fetal growth retardation, low birth-weight, child undernutrition, and ailments in adult children of disadvantaged mothers” (Mayra Buvinić et al<sup>14</sup> citing Osmania

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<sup>13</sup> Gita Sen and Pirooska Östlin, Final Report to the WHO Commission on Social Determinants of Health, September 2007

<sup>14</sup> Mayra Buvinić, André Médecin, Elisa Fernández, and Ana Cristina Torres, Gender Differentials in Health, Chapter in Dean T. Jamison et al (edited) Disease Control Priorities in Developing Countries, OUP and World Bank, Washington DC, 2006

and Sen 2003). Selective abortion of the female foetus, female infanticide and neglect of the health of the female child are among the factors that explain the decline in child sex ratio.

Table 3 presents the sex ratio of Punjab and its districts from 1901 to 2001 and shows that on average, an increase in the sex ratio was registered in each Census year throughout the century with the exception of the period 1901-11 and 1991-2001, when the decline was by 52 and 8 points respectively. During the period from 1911 to 1991, the largest increase was registered between 1931-41 at 21 points and the smallest increase in 1981-91 at 3 points. Districts that registered a sex ratio that was higher than the average for Punjab were Hoshiarpur with a ratio of 935, Nawanshehar with 913 and Gurdaspur, Kapurthala, Muktsar, FG Sahib, Monga, Jalandhar, Faridkot and Mansa with ratios ranging from 888 to 875. The sex ratio in the districts of Amritsar, Rup Nagar, Sangrur, Bathinda, Patiala, Ferozepur and Ludhiana was less than the average for Punjab with Ludhiana registering the lowest ratio at 824. However, Amritsar registered a 13 point increase in the sex ratio in 2001 that was larger than the average increase of 11 for the State. Faridkot, Kapurthala and Mansa also registered increases in the sex ratio while there was no change in Monga. All other districts registered a decline and the worst performers were Faridkot and Ludhiana where the decline was as high as 20 (see Table 3).

**Table 3: Sex Ratio of Punjab and its Districts 1901-2001**

Districts	1901	1911	1921	1931	1941	1951	1961	1971	1981	1991	2001
<b>Punjab</b>	<b>832</b>	<b>780</b>	<b>799</b>	<b>815</b>	<b>836</b>	<b>844</b>	<b>854</b>	<b>865</b>	<b>879</b>	<b>882</b>	<b>874</b>
Amritsar	829	781	796	803	841	841	854	856	871	873	874
Bathinda	N.A.	N.A.	N.A.	N.A.	N.A.	839	834	851	861	884	865
FG Sahib	N.A.	N.A.	N.A.	N.A.	N.A.	856	849	866	879	883	881
Faridkot	N.A.	N.A.	N.A.	N.A.	N.A.	773	815	831	841	871	851
Ferozepur	826	778	802	814	810	835	840	876	884	895	883
Gurdaspur	853	774	794	809	843	846	869	890	907	903	888
Hoshiarpur	878	828	856	867	879	877	902	899	919	924	935
Jalandhar	848	783	807	841	859	857	867	883	890	897	882
Kapurthala	N.A.	N.A.	N.A.	N.A.	N.A.	880	886	889	898	896	886
Ludhiana	829	765	784	791	832	852	856	848	860	844	824
Mansa	N.A.	N.A.	N.A.	N.A.	N.A.	824	830	852	869	873	875
Monga	N.A.	N.A.	N.A.	N.A.	N.A.	867	862	866	881	884	883
Muktsar	N.A.	N.A.	N.A.	N.A.	N.A.	862	846	863	885	880	886
Nawanshehar	856	796	821	848	865	876	900	887	898	900	913
Patiala	N.A.	N.A.	N.A.	N.A.	N.A.	809	831	850	870	882	864



Rup Nagar	807	756	781	789	802	812	812	854	862	870	870
Sangrur	N.A.	N.A.	N.A.	N.A.	N.A.	820	832	840	860	870	868

Source: Census of India, 2001, Series-4, Punjab (Provisional Population Totals, Paper 1 of 2001) cited in Punjab HDR

Note:- N.A.= Not Available

Causing immense concern is the fact that the child sex ratio (0-6 years) at 793 is 81 points below the 874 for the total population, reflecting severe discrimination of the girl child. The gap between the child sex ratio and population sex ratio is more than 100 for Hoshiarpur, Gurdaspur, Kapurthala and Nawanshehar. The child sex ratio worsened in both rural and urban areas across all districts of Punjab during the decade from 1991 to 2001. This decline exceeded 100 points in Faridkot, Kapurthala, Gurdaspur and Patiala (Table 4).

**Table 4: Sex Ratio in the 0-6 Age Group for Punjab and its Districts**

State/Districts	Sex Ratio in 0-6 age group - 1991 Census			Sex Ratio in 0-6 age group - 2001 Census			Change in Points		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
<b>Punjab</b>	<b>875</b>	<b>878</b>	<b>866</b>	<b>793</b>	<b>795</b>	<b>789</b>	<b>-82</b>	<b>-83</b>	<b>-77</b>
Amristsar	861	864	856	783	789	772	-78	-75	-84
Bathinda	860	866	844	779	789	756	-81	-77	-88
FG Sahib	865	867	861	805	805	806	-60	-62	-55
Faridkot	874	872	881	754	747	774	-120	-125	-107
Ferozepur	887	894	864	819	824	804	-68	-70	-60
Gurdaspur	878	881	868	775	789	729	-103	-92	-139
Hoshiarpur	884	887	873	810	813	800	-74	-74	-73
Jalandhar	886	891	879	797	806	786	-89	-85	-93
Kapurthala	879	875	891	775	773	779	-104	-102	-112
Ludhiana	877	886	869	814	812	816	-63	-74	-53
Mansa	873	883	814	779	780	775	-94	-103	-39
Monga	867	867	866	819	820	811	-48	-47	-55
Muktsar	858	864	839	807	810	798	-51	-54	-41
Nawanshehar	900	898	913	810	811	805	-90	-87	-108
Patiala	871	870	872	770	764	786	-101	-106	-86
Rup Nagar	884	883	886	791	787	800	-93	-96	-86
Sangrur	873	877	863	784	779	798	-89	-98	65

Source:-Provisional Series, Paper 2 of Punjab, Census of India, 2001 cited in Punjab HDR (2004)

Provisional estimates of the 2011 Census have just become available and are presented in Table 5.

**Table 5: Sex Ratio of Total population and child population 0-6 years: 2001 and 2011**

State /UT Code	India/States/Union Territory <sup>#</sup>	Sex ratio (females per 1,000 males)			
		Total population		Child population in the age group 0-6	
		2001	2011	2001	2011
	<b>INDIA</b>	<b>933</b>	<b>940</b>	<b>927</b>	<b>914</b>
01	Jammu & Kashmir	892	883	941	859
02	Himachal Pradesh	968	974	896	906
03	Punjab	876	893	798	846
04	Chandigarh <sup>#</sup>	777	818	845	867
05	Uttarakhand	962	963	908	886
06	Haryana	861	877	819	830
07	NCT of Delhi <sup>#</sup>	821	866	868	866
08	Rajasthan	921	926	909	883
09	Uttar Pradesh	898	908	916	899
10	Bihar	919	916	942	933
11	Sikkim	875	889	963	944
12	Arunachal Pradesh	893	920	964	960
13	Nagaland	900	931	964	944
14	Manipur	974	987	957	934
15	Mizoram	935	975	964	971
16	Tripura	948	961	966	953
17	Meghalaya	972	986	973	970
18	Assam	935	954	965	957
19	West Bengal	934	947	960	950
20	Jharkhand	941	947	965	943
21	Orissa	972	978	953	934
22	Chhattisgarh	989	991	975	964
23	Madhya Pradesh	919	930	932	912
24	Gujarat	920	918	883	886
25	Daman & Diu <sup>#</sup>	710	618	926	909
26	Dadra & Nagar Haveli <sup>#</sup>	812	775	979	924
27	Maharashtra	922	925	913	883
28	Andhra Pradesh	978	992	961	943
29	Karnataka	965	968	946	943
30	Goa	961	968	938	920
31	Lakshadweep <sup>#</sup>	948	946	959	908
32	Kerala	1058	1084	960	959
33	Tamil Nadu	987	995	942	946
34	Puducherry <sup>#</sup>	1001	1038	967	965
35	Andaman & Nicobar Islands <sup>#</sup>	846	878	957	966

Source: Census

It needs to be noted that:

- i) the female-male or sex ratio for India increased from 933 to 940 (by 7 points).
- ii) the female-male or sex ratio for Punjab increased from 876 to 893 (by 17 points);
- iii) there was a slight improvement in Punjab's rank from 28<sup>th</sup> to 27<sup>th</sup> out of 35 states and union territories based on the sex ratio (Table 5);
- iv) The child sex ratio for India is cause for immense concern. Worryingly, the female-male child sex ratio (0-6 age group) registered a decrease from 927 to 914 (by 13 points).
- v) The child sex ratio (0-6 years) worsened in all except 8 states. The largest improvement was in Punjab at 48, followed by Chandigarh at 22, Haryana at 11 and Himachal Pradesh at 10. Other States/UTs that showed an improvement in the child sex ratio were Andaman & Nicobar Islands, Mizoram, Tamil Nadu and Gujarat. The worst records of fall in the child sex ratio were in Jammu & Kashmir, Lakshadweep and Dadra & Nagar Haveli followed by Maharashtra and Rajasthan.
- vi) Fortunately, the female-male child sex ratio (0-6 age group) for Punjab increased from 798 to 846 (by 48 points). However, this is still 68 points lower than the average for India and reflects the severe discrimination faced by the girl child in Punjab and in India.
- vii) Punjab has improved its rank from 35<sup>th</sup> or worst to 34<sup>th</sup> or second worst of 35 states and union territories.
- viii) Punjab has achieved the largest improvement in the country during the period from 2001 to 2011 (see Table 6).
- ix) Notwithstanding the fact that Punjab has a long way to go before it catches up with the average child sex ratio for the country, this is commendable since the worsening trend has been arrested and the improvement exceeds the targets that were set.

**Table 6: Difference in Child Sex Ratio (0-6 years) between 2001 and 2011**

State/UT	Difference	State/UT	Difference
Punjab	48	Tripura	-13
Chandigarh <sup>#</sup>	22	Daman & Diu <sup>#</sup>	-17
Haryana	11	Uttar Pradesh	-17
Himachal Pradesh	10	Andhra Pradesh	-18
Andaman & Nicobar Islands <sup>#</sup>	9	Goa	-18
Mizoram	7	Sikkim	-19
Tamil Nadu	4	Orissa	-19
Gujarat	3	Nagaland	-20
Kerala	-1	Madhya Pradesh	-20
Puducherry <sup>#</sup>	-2	Jharkhand	-22
NCT of Delhi <sup>#</sup>	-2	Uttarakhand	-22
Meghalaya	-3	Manipur	-23
Karnataka	-3	Rajasthan	-26
Arunachal Pradesh	-4	Maharashtra	-30
Assam	-8	Lakshadweep <sup>#</sup>	-51

Bihar	-9	Dadra & Nagar Haveli <sup>#</sup>	-55
West Bengal	-10	Jammu & Kashmir	-82
Chhattisgarh	-11	<b>India</b>	-13

Source: Calculations based on Table 5

As can be seen from Table 7 Punjab has managed to arrest the decline in child sex ratio that had registered a sharp fall from 908 in 1981 to a low of 798 in 2001 and subsequently increased to 846 as per provisional estimates for 2011. While discrimination against the girl child remains an issue that needs to be addressed, steps taken to prevent female foeticide and infanticide have led to gains being registered over this decade.

**Table7: Child Sex Ratio: Girls per 1000 boys aged 0-6, 1961-2011**

	<b>India</b>	<b>Punjab</b>
1961	976	894
1971	964	899
1981	962	908
1991	945	875
2001	927	798
2011	914	846

In a meeting held on 10<sup>th</sup> June 2010 between Deputy Chairman, Planning Commission and Chief Minister of Punjab, for finalisation of the Annual Plan 2010-11, a Member of the Planning Commission stated that while Punjab had performed better than the national average on most indicators for health and women and child welfare, this was not good enough and the State should try to achieve the targets set under the monitorable indicators. The child sex ratio had improved but not enough. However the State was to be commended for implementation of the PNDT Act, specially for filing court cases, canceling licenses and convicting the offenders (see Summary Record of the meeting).

Gender Responsive Budgeting requires that attention be drawn to the fact that declining sex-ratios are evidence of the existence of the missing girl child and reflection of rampant gender bias. This is now well documented and is on the radar of the Government at the Centre and in the State. Understanding this is critical to understanding the occurrence of malnutrition, anaemia, violence against women and adequate access to health care. However, while tracking the sex ratio and taking steps to implement the PNDT Act, prevent female foeticide

and infanticide are critical, Gender Responsive Budgeting also requires that steps be taken to change mind-sets and create a safe and conducive environment for and survival and growth of the girl child and adequate budgets allocated for enabling this, especially in districts where the sex ratio is low or declining.

### III.2 Estimates of Morbidity: Punjab and India

Analysis of data from NSS 60<sup>th</sup> Round shows that Punjab reported higher levels of ailment per 1000 males and females in both rural and urban areas than the all-India estimates. Further, the proportion of females reporting ailments per 1000 was significantly higher than corresponding estimates for males (Table 8 below).

**Table 8: Number per 1000 males and females reporting ailment during the last 15 days**

	<b>Punjab</b>	<b>Punjab</b>	<b>All India</b>	<b>All India</b>	<b>Punjab</b>	<b>All India</b>
	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Female/Male</b>	<b>Female/Male</b>
Rural	114	160	83	93	1.40	1.12
Urban	100	115	91	108	1.15	1.19
Rural and Urban	109	146	85	97	1.34	1.14

Source: Extracted from Table 9 below

Disaggregating the estimates by 12 monthly per capita expenditure classes shows that ailments among females were reportedly higher than for males for all except 3 expenditure classes in rural and five expenditure classes in urban Punjab. Corresponding estimates showed that on average ailments reported by females exceeded those by males for all except the lowest two expenditure classes in rural and lowest expenditure class in urban India on average (Table 9).

**Table 9: Number per 1000 of persons reporting ailment during the last 15 days by mpce class for males and females**

<b>Rural</b>		<b>mpce class</b>												
		0-225	225-255	255-300	300-340	340-380	380-420	420-470	470-525	525-615	615-775	775-950	950+	all
Punjab	Male	225	0	21	47	140	46	108	89	28	95	186	155	114
	Female	62	0	51	91	242	73	78	129	162	175	153	228	160
All India	Male	65	57	61	65	72	79	80	88	88	106	123	142	83
	Female	63	56	66	67	81	81	92	99	100	119	151	189	93

<b>Urban</b>		<b>mpce class</b>												
		0-225	225-255	255-300	300-340	340-380	380-420	420-470	470-525	525-615	615-775	775-950	950+	all
Punjab	Male	41	51	92	55	45	77	182	98	120	78	131	139	100
	Female	0	0	36	76	109	72	103	142	162	142	232	171	115
All India	Male	68	86	80	77	80	73	91	85	88	111	104	132	91
	Female	61	92	85	89	90	98	113	102	115	126	127	168	108
<b>Rural + Urban</b>		<b>mpce class</b>												
		0-225	225-255	255-300	300-340	340-380	380-420	420-470	470-525	525-615	615-775	775-950	950+	all
Punjab	Male	104	30	59	52	97	58	148	93	68	88	182	153	109
	Female	25	0	44	81	175	73	91	134	162	163	159	223	146
All India	Male	66	62	65	69	74	77	83	87	88	107	119	139	85
	Female	62	61	70	74	82	84	98	100	104	121	145	181	97

\* during the last 15 days

Source: Table 36, Report No 507: Morbidity, Health Care and the Condition of the Aged, NSS 60<sup>th</sup> Round, Jan.-June, 2004

**Table 10: Number of Persons Suffering from Chronic Diseases in Punjab by Age, Sex and Residential Status (per 10000 Persons)**

<b>Age-group</b>	<b>Punjab (Rural)</b>			<b>Punjab (Urban)</b>			<b>Rural</b>	<b>Urban</b>
	<b>M</b>	<b>F</b>	<b>P</b>	<b>M</b>	<b>F</b>	<b>P</b>	<b>Ratio Female/Male</b>	
0-14	247	269	257	473	334	405	1.09	0.71
15-24	759	900	827	416	607	502	1.19	1.46
25-44	2459	3503	2970	1724	2342	1998	1.42	1.36
45-59	6689	5772	6238	4097	7042	5513	0.86	1.72
60+ above	9717	6708	8458	8036	7326	7718	0.69	0.91
Not recorded	-	-	-	-	-	-		
<b>All ages</b>	2348	2197	2277	1621	1993	1794	0.94	1.23

Source: 'NSS 28<sup>th</sup> Round', *Sarvekshana*, Volume IV, No. 1 & 2, 1980 and own calculations

Data in Table 10 based on the 28<sup>th</sup> Round of the NSS showed that there was a rise in suffering from chronic diseases with increase in age in both the rural and urban areas of Punjab. As can be seen from Table 10 on average the prevalence of chronic morbidity among females was significantly higher than that among males in urban areas and was a little lower in rural areas. However, if the average is disaggregated by age-group, in rural areas, chronic morbidity among females was higher than males in the age groups 0-14, 15-24 and especially in age group 25-44. Chronic morbidity among women relative to men declined in

rural areas after the age of 45. In comparison in urban areas chronic morbidity among females was significantly higher than among men in the age groups 15-24, 25-44 and 45-59 and lower among the very young and old.

Mayra Buvinić et al op cit point out that even though women in India report more illness than men, hospital records show that men receive more treatment. Possible explanations include:

- i) issues of access, affordability, adequacy and friendliness of health and social infrastructure for meeting women's needs;
- ii) restricted mobility, income and time burden;
- iii) stigma, discrimination and lack of control over health budgets.

Based on the evidence provided above it can be concluded that reported morbidity and chronic morbidity is relatively higher in Punjab and health related issues need priority attention. Further reported morbidity levels are higher for females relative to males for most mpce classes. While all health issues need to be addressed, Gender Responsive Budgeting would require the Health Department to identify:

- the reasons for higher prevalence of chronic morbidity among females in age groups 0-14, 15-24 and especially in age group 25-44 in rural areas and among males in age groups 45-59 and above 60 in rural areas.
- the reasons for higher prevalence of chronic morbidity among females in age groups 15-24, 25-44 and 45-59 and among males in age groups 0-14 and above 60 in urban areas.
- collect data to see if these trends have persisted over time or changed.
- collect data to see if these trends occur across all districts or are peculiar to specific districts.
- address the causal factors in each case.
- Determine why despite reported morbidity being higher among women than men, this is not reflected in access to treatment

#### **IV. Allocations for Healthcare and Cost related Issues**

The share of total expenditure allocated to health increased between 1981 and 1987 after which it declined across almost all states during the 1990s and from 2001-05. Not a single State listed in Table 11 below showed a uniform increase in the share of the expenditure allocated to Healthcare over this period. Where there was an increase, it was occasional and marginal in most cases. The exceptions were Himachal Pradesh in 1996, Rajasthan in 1998 and Uttar Pradesh in 2001. In 1987 Punjab allocated 10.52% of its total expenditure to

healthcare. Only two other states, Himachal Pradesh and Nagaland had allocated higher proportions of their total expenditure to healthcare, with allocations of 13.5% and 10.88% respectively. By 1998 the share of expenditure allocated to healthcare had halved to 4.93% and then declined further till it reached 3.10% in 2005.

**Table 11: Health Expenditure as Percentage of Total State Expenditure**

State	1981	1987	1991	1996	1998	2001	2003	2005
Andhra Pradesh	5.80	7.88	5.53	4.65	5.44	4.74	3.96	3.53
Assam	3.96	10.21	NA	5.84	5.87	4.66	3.69	3.06
Bihar	3.78	8.49	5.10	5.79	5.24	4.01	3.17	3.24
Gujarat	4.38	9.58	5.03	4.70	4.57	3.38	3.21	3.05
Haryana	4.33	8.25	4.11	2.95	3.27	3.26	2.88	2.59
Himachal Pradesh	6.63	13.50	3.32	6.16	7.04	5.64	4.50	5.08
Jammu and Kashmir	3.79	12.50	5.56	5.50	4.97	4.89	5.30	4.78
Karnataka	3.79	8.23	5.40	5.28	5.85	5.11	4.17	3.49
Kerala	6.56	9.85	7.21	6.53	5.68	5.25	4.74	4.71
Madhya Pradesh	4.94	10.11	5.16	4.81	4.57	5.09	4.11	3.39
Maharashtra	4.85	9.38	5.13	4.56	4.29	3.87	3.71	3.51
Nagaland	5.39	10.88	5.96	5.95	5.68	4.87	4.65	4.68
Orissa	5.17	8.50	5.13	5.16	4.82	4.15	3.75	3.90
Punjab	3.67	10.52	6.73	4.62	4.93	4.54	3.54	3.10
Rajasthan	4.85	14.48	6.50	5.70	7.97	5.16	4.24	3.94
Tamil Nadu	6.18	10.04	6.91	6.29	6.28	4.86	4.10	4.20
Uttar Pradesh	4.69	9.08	6.31	6.03	1.74	3.98	3.75	4.00
West Bengal	6.30	9.73	8.37	6.43	NA	5.63	4.95	4.93

Source: GoI (2006a) cited in N.J. Kurian (2011). Issues of Health and Equity in India, chapter in India: Social Development Report 2010, Oxford University Press

The detailed budgetary allocations on Revenue Account are presented in Table 12 below and reflect the fact that the Health and Family Welfare account for only 3.25 to 3.80 per cent of the total Revenue Expenditure of the State during the period from 2006-07 to 2009-10. This is less than one-third to one-fourth of the allocation to Education, Sports, Art and Culture. This is also reflected in the Plan allocations, which provide 1.40 per cent of total Plan outlay to medical and public health, with individual annual plan allocations varying between 0.64 and 1.98 per cent. The allocation to nutrition is also low at 1.14 per cent for the Plan (Table 13).

The allocations for Healthcare in the Punjab State Budget and in the Plan need to be increased substantially if healthcare is to be given the priority it deserves.



**Table 12: State Budget of Punjab - Expenditure on Revenue Account**

	2006-07	2007-08	2008-09 (Revised)	2009-10 (Budget)
<b>Type of Expenditure</b>	<b>Percentage to total Expenditure</b>			
<b>I. General Services</b>	55.75	55.90	52.37	55.13
(i) Organs of State	0.91	0.80	0.91	0.88
(ii) Fiscal Services	1.24	0.94	0.91	0.89
(iii) Interest payments and Servicing Debt of Services	22.39	19.63	18.17	17.65
(iv) Administrative services	9.90	8.94	9.26	11.51
(v) Pension and Miscellaneous General Services	21.31	25.59	23.12	24.2
<b>II. Social Services</b>	22.13	18.79	23.92	23.49
(i) Education, Sports, Art and Culture	12.50	11.6	12.50	13.11
(ii) Health and Family Welfare	3.72	3.28	3.80	3.25
(iii) Water Supply, Sanitation, Housing and Urban Development	1.87	1.33	1.12	1.03
(iv) Information and Broadcasting	0.10	0.08	0.12	0.11
(v) Welfare of Scheduled Castes, Scheduled Tribes and Other Backward Classes	0.43	0.25	0.94	0.93
(vi) Labour and Labour Welfare	0.33	0.29	0.31	0.37
(vii) Social Welfare and Nutrition	3.13	1.90	5.07	4.63
(viii) Others	0.05	0.06	0.06	0.06
<b>III. Economic Services</b>	20.35	23.76	20.49	18.32
(i) Agriculture and Allied Activities	2.56	2.87	3.23	2.99
(ii) Rural Development	0.36	0.29	0.8	0.36
(iii) Special Area Programmes	-	-	-	-
(iv) Irrigation and Flood Control	2.80	2.46	2.59	2.47
(v) Energy	7.70	12.36	9.75	8.60
(vi) Industry and Minerals	0.74	0.56	0.51	0.46
(vii) Transport	2.97	1.58	1.67	1.51
(viii) Science, Technology and Environment	0.01	0.06	0.05	0.05
(ix) General Economic Services	3.21	3.58	1.89	1.88
<b>IV. Grants-in-Aid Contributions</b>	1.77	1.55	3.22	3.06
<b>Total (I+II+III+IV)</b>	100.00	100.00	100.00	100.00

Source: Government of Punjab (2009). Statistical Abstract, Economic & Statistical Organisation, Government of Punjab. Pages. 660-661.

**Table 13: Eleventh Five Year Plans and Annual Plans of Punjab (in lakh Rupees)**

Sub Head	Approved outlay 11th Plan	Approved outlay Annual	Actual expenditure Annual	Approved outlay Annual Plan	Approved outlay Annual

		Plan	Plan		Plan
	2007-12	2008-09	2008-09	2009-20	2010-11
Medical and Public Health	40621.00	9544.60	4423.74	16938.92	14866.86
Nutrition	32859.85	5967.00	4777.68	11380.00	13280.00
<b>Total Social Services</b>	<b>990167.05</b>	<b>156595.35</b>	<b>204549.04</b>	<b>221391.15</b>	<b>235411.20</b>
<b>Grand Total (I - XI)</b>	<b>2892300.00</b>	<b>621000.00</b>	<b>692509.87</b>	<b>862500.00</b>	<b>905000.00</b>
Percent of total outlay					
Medical and Public Health	1.40	1.54	0.64	1.96	1.64
Nutrition	1.14	0.96	0.69	1.32	1.47
<b>Total Social Services</b>	<b>34.23</b>	<b>25.22</b>	<b>29.54</b>	<b>25.67</b>	<b>26.01</b>

Source: Statistical Abstract of Punjab 2009, pages 708-9

As can be seen from Table 14, per capita health expenditure in Punjab in 2001-02 was Rs 1,530 and was third highest in India. However, public expenditure was only 16.8 per cent per cent of this and this was less than half the 37.8 per cent spent by the State in Himachal Pradesh. This has serious consequences for the cost of health care and out of pocket expenses leading to health burden on citizens and leads to debt and/or denial of access to healthcare especially to those who are poor and especially women in poor households. Singh (2010) points out that nearly 41.6% of total credit acquired by marginal and small farmers in Punjab was for healthcare purposes. High costs of medical care are a barrier to access to healthcare for the poor and especially for women among disadvantaged groups.

**Table 14: Public and Private Expenditure on Health in Major States, 2001-2**

States	Per Capita Health Expenditure (Rs.)			Public Expenditure as % of Total Expenditure
	Public	Private	Total	
Andhra Pradesh	182	858	1039	17.5
Assam	176	393	569	30.9
Bihar	92	687	779	11.8
Gujarat	147	670	816	18.0
Haryana	163	1408	1570	10.4
Himachal Pradesh	493	812	1305	37.8
Jammu and Kashmir	271	790	1061	25.5
Karnataka	206	506	712	28.9
Kerala	240	1618	1858	12.9
Madhya Pradesh	132	733	864	15.2
Maharashtra	196	815	1011	19.4

Orissa	134	449	582	23.0
Punjab	258	1273	1530	16.8
Rajasthan	182	415	597	30.4
Tamil Nadu	202	644	846	23.9
Uttar Pradesh	84	1040	1124	7.5
West Bengal	181	593	775	23.4
All India	207	790	997	20.8

Source: NHA, India, 2001-2, GoI (2006a) cited in Kurian (2011) op.cit.

There was a sharp 10 per cent decline in the proportion of persons seeking hospitalization in government hospitals in rural Punjab (Table 15). The reasons for this may include the significant increase in cost of hospitalized treatment in government hospitals in rural areas as can be seen in Table 16. Average expenditure per hospitalization in government hospitals in rural Punjab increased sharply by 2.68 times between the 52<sup>nd</sup> and 60<sup>th</sup> NSS Rounds compared with an increase of only 1.56 times for rural India and 2.11 times for non-government hospitals in rural areas. In comparison, the average expenditure per hospitalization in non-government hospitals in urban areas of Punjab at 3.11 times exceeded the increase in government hospitals at 1.9 times. There may be additional factors that need attention and data regarding the gender disaggregated impact of this escalation in costs needs to be collected. Meanwhile, non-hospitalised treatment sought at government hospitals increased in both rural and urban Punjab.

**Table 15: Trend in hospitalised and non-hospitalised treatments received from Government Sources - Rural & Urban - 52nd and 60th rounds**

	Treated in govt. hospital- Rural		Treated in govt. hospital- Urban	
	52nd	60th	52nd	60th
Hospitalised Treatment Number (per 1000)				
Punjab	394	294	276	264
All India	453	417	431	382
Non-hospitalised treatment (per cent)				
Punjab	7	16	6	18
All India	19	22	20	19

**Table 16: Average total expenditure (Rs.) per hospitalisation by type of hospital for rural and urban areas of 15 Major States - 52nd & 60th rounds (1995-96 and 2004)**

	Rural				Urban			
	Govt. hospitals		Other hospitals		Govt. hospitals		Other hospitals	
	52nd	60th	52nd	60th	52nd	60th	52nd	60th
Punjab	3645	9,774	6171	13,044	5436	10,323	6130	19,035
All India	2080	3,238	4300	7,408	2195	3,877	5344	11,553

**Table 17: Average medical expenditure (Rs.) for treatment under different heads of treatment during stay at public hospitals as inpatient during last 365 days per hospitalization case receiving medical treatment - 60th round - Rural and Urban**

State	Doctors fee	Diag. test	Other services, bed	Medicine	Blood etc.	Food	Total
<b>Rural</b>							
Rajasthan	77	697	59	3187	109	253	4381
Haryana	114	327	136	3268	14	123	3981
Uttar Pradesh	411	439	341	1730	117	166	3204
Bihar	86	871	71	1578	130	342	3078
Punjab	176	37	223	1624	45	344	<b>2449</b>
Assam	233	280	119	1363	256	142	2393
Orissa	107	151	47	1496	40	220	2060
Gujarat	11	179	12	1113	182	186	1683
West Bengal	21	180	131	1098	91	87	1610
Jharkhand	60	110	60	974	2	214	1419
Madhya Pradesh	34	54	22	933	25	125	1194
Andhra Pradesh	76	72	23	702	30	104	1008
Karnataka	116	110	20	566	6	91	908
Kerala	36	182	41	497	15	111	883
Maharashtra	38	23	30	457	73	146	768
Chhattisgarh	237	43	0	338	0	9	627
Tamil Nadu	15	20	27	102	1	90	255
All	61	175	64	976	55	137	1467
<b>Urban</b>							
	Doctors fee	Diag. test	Other services, bed	Medicine	Blood etc.	Food	Total
Punjab	1041	445	397	3882	90	196	<b>6051</b>
Rajasthan	96	612	214	2493	336	250	4003
Orissa	25	349	31	2514	36	308	3263
Uttar Pradesh	280	396	155	1524	75	137	2566
Assam	76	604	9	1451	5	262	2407
West Bengal	43	457	147	1103	50	82	1881
Jharkhand	57	276	91	1174	4	68	1670
Madhya Pradesh	23	100	29	920	5	109	1187
Gujarat	100	81	49	692	76	69	1068
Haryana	11	115	203	636	4	42	1010
Bihar	0	148	0	756	0	24	927
Kerala	37	132	38	495	50	153	906
Andhra Pradesh	90	77	50	496	36	47	797
Karnataka	4	89	30	342	61	45	571
Maharashtra	17	42	23	309	74	30	494
Tamil Nadu	7	25	10	138	16	60	255
Chhattisgarh	0	5	0	147	9	35	197
All	66	215	83	886	65	107	1422

Source: [http://www.whoindia.org/LinkFiles/Health\\_Finance\\_NSSO\\_Report.pdf](http://www.whoindia.org/LinkFiles/Health_Finance_NSSO_Report.pdf)

Average medical expenditure for treatment in Punjab is highest of all States in urban areas at Rs 6051/- due to relatively high charges for Doctor's fee and medicine and fifth highest at Rs 2449/- in rural areas based on estimates provided by the NSS 60<sup>th</sup> Round. As can be seen from Table 17, costs in rural areas of Punjab are 10 times higher than costs estimated for rural Tamil Nadu and two times higher than for rural India.

## **V. Norms, Shortfall and Barriers to Access: CHCs, PHCs and Medical Personnel**

Unsatisfactory health indices are an indication of the limited success of the public health system in meeting the preventive and curative requirements of the general population (National Health Policy 2002). Norms and shortfalls must be seen in this context.

According to the standard norms (NRHM Framework for Implementation) there should be:

- i) a Sub-Centre (SC) on the population norm of 1 per 5000 population in general areas and 1 per 3000 population in tribal areas;
- ii) a PHC on the population norm of 1 per 30,000 population in general areas and 1 per 20,000 population in tribal / desert areas; and
- iii) a CHC on the population norm of 1 per 1,20,000 population in general areas and 1 per 80,000 population in tribal / desert areas.

Narinder Deep Singh<sup>15</sup> (2010) points out that in rural areas of Punjab, there are only 2,858 SCs against the requirement of 3,219 (according to population estimates of 2001 Census, i e, 1,60,96,488 persons), 484 PHCs against the requirement of 537 and 126 CHCs, whereas 134 are required. Further, he estimates that the requirement as per norms is much higher based on projected population estimates of rural Punjab for the year 2008, i e, 1,84,62,672 persons (calculated on the basis of state's average annual population growth rate of previous decade, i.e., 2.1% per annum).

“Due to the existence of a smaller number of public health institutions than their actual requirement, these institutions in rural areas are overburdened in terms of both area and the number of persons dependent on them. On an average, one PHC covers nearly 100 sq km, whereas one CHC caters to 383 sq km of area. One doctor is, therefore, available for 26 villages (on an average basis), as one PHC is available for 26 villages. And one CHC is

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<sup>15</sup> Narinder Deep Singh, Rural Healthcare and Indebtedness in Punjab, Economic and Political Weekly, Vol 45 No. 11 March 13 - March 19, 2010

available for every 101 villages, which sounds unbelievable. Some of the basic facilities in these government health institutions are not available, such as electricity (404 SCs and five PHCs), water (389 SCs and 24 PHCs) and all-weather motorable roads (134 SCs and 10 PHCs) do not exist (Table 18).”

**Table 18: Facilities in Public Health Institutions in Rural Punjab (as on March 2008)**

Particulars	SCs	PHCs	CHCs
(1) Total no of institutions	2,858	484	126
(2) Population covered by one	6,460	38,146	1,46,529
(3) Population to be covered as per IPHN	5,000	20,000	120,000
(4) Average rural area covered (sq km) by one	16.89	99.76	383.20
(5) Average no of villages covered by one	4	26	101
(6) Institutions without buildings or to be constructed	1,025	82	10
(7) Institutions without electricity	404	5	
(8) Institutions without regular water supply	389	24	
(9) Without all-weather motorable road	134	10	

Source: *Rural Health Statistics*, 2009 cited in Narinder Deep Singh (2010) op.cit.

Estimates of rural population served by each PHC and CHC are presented in Table 19 and reflect deviation from population norms. All except three districts of Punjab, i.e., Faridkot, Tarn Taran and Muktsar, did not meet these norms with Sangrur having 1 CHC instead of the mandated 3. Only Muktsar had 1 PHC for 29765 people. All other districts did not have the required number of PHCs as per norms and the PHC-population ratio was as high as 1: 63499 in Kapurthala. It may be important to note that the estimates in Table 19 underestimate the deviations since PHCs and CHCs are as per availability in April 2009 while data for rural population is for 2001.

**Table 19: Rural Population served by each CHC and PHC**

District	Rural Population served by each		
	CHC		PHC
Rupnagar	-	Kapurthala	63499
Sangrur	524495	Ludhiana	53567
S.A.S. Nagar	427044	Tarn Taran	51662
Fatehgarh Sahib	386950	Bathinda	48914
Barnala	366364	Barnala	45796
Amritsar	348736	Mansa	45527

Ludhiana	267836	Faridkot	44665
Ferozpur	259076	Ferozpur	43179
Jalandhar	257679	Sangrur	41960
S.B.S. Nagar	253201	Muktsar	41352
Bathinda	207885	Gurdaspur	41284
Mansa	182110	Hoshiarpur	40988
Moga	179054	Rupnagar	40636
Hoshiarpur	169809	Moga	39790
Kapurthala	169331	Jalandhar	39643
Gurdaspur	156879	S.A.S. Nagar	38822
Patiala	148464	Amritsar	36076
Faridkot	119107	Patiala	35836
Tarn Taran	118085	S.B.S. Nagar	33760
Muktsar	115786	Fatehgarh Sahib	29765

Note: Rural population estimates are for 2001; CHCs and PHCs are for 2009

Source: Estimated based on data in Government of Punjab, Statistical Abstract 2009 (pages 51 to 54 and 486).

Narinder Deep Singh (2010) points out that acute manpower shortages exist in state run medical institutions in rural areas. He estimates a shortage of 283 and 294 doctors in PHCs and CHCs (i.e., nearly 60% shortage), 1,380 health workers, 650 health assistants/ auxiliary nurse midwives (67.2% shortage), 340 laboratory technicians and 342 nurses/staff nurses exist in these institutions (Table 20).

**Table 20: Manpower Availability in Rural Health Institutions of Punjab** (as on March 2008)

Particulars	Required	Available	Shortage
Health workers (SCs) (male + female)	5716	4336	1380 (24.1)
Health asst/ANMs (PHCs) (male + female)	968	318	650 (67.2)
Nurse/staff nurse (PHCs + CHCs)	1366	1024	342 (25)
Lab technicians PHCs + CHCs)	610	270	340 (55.7)
Radiographers (CHCs)	126	61	65 (51.6)
Doctors (PHCs)	484	201	283 (58.5)
Doctors (CHCs)	504	210	294 (58.3)
(a) Physicians	126	56	70 (55.6)
(b) Obstetricians and gynecologists	126	46	80 (63.5)
(c) Pediatricians	126	39	87 (69.5)
(d) Surgeons	126	69	57 (45.2)

Note: Figures in parentheses are percentages

Source: Narender Deep Singh (2010) based on Rural/Health Statistics, 2009

He notes that “the absenteeism of medical staff, poor/outdated/non-working medical equipment and lack of basic infrastructure are some of the other problems which rural inhabitants face” and lays the blame on the reduction in state government expenditure on health for leading to “overdependence on private sector for getting health services” and “out-of-pocket expenditure”. He notes that the rural people, who are “more prone to diseases like tuberculosis, cancer, liver dysfunction, etc, due to nutritional imbalance, lack of proper sanitation facilities and residual effect of agro-chemicals, are forced to avail of the services of private medical treatment, which are quite costly.

The poor rural people pay from their own sources, which are many times inadequate, forcing them to acquire credit sometimes at an exorbitant rate of interest, thereby increasing the debt burden on them.” He found “although nearly 11% marginal and 9.4% small farmers were suffering from serious ailments requiring immediate medical assistance, due to lack of funds they were unable to avail of these services.”

While the population served per doctor and para medical staff has improved in Punjab between 1980 and 2008, spatial disparities in access to medical care are evident from the data given in Table 21 below. Whereas the ratio of doctors to population is 1:563 in Faridkot and 1:610 in Patiala, there is only 1 doctor for 9,383 people in Fatehgarh Sahib. Similarly, there are sharp disparities in population served by paramedical personnel with 1 midwife for 350 people in Faridkot compared with 1 midwife for 5,754 persons in Fatehgarh Sahib; and 1 nurse for 394 people in Ludhiana compared with 1 nurse for 2,946 people in SAS Nagar.

**Table 21: Population Served per Medical and Para-Medical Personnel in Punjab in 2008**

Year/District	Population Served Per		
	Doctor	Midwife	Nurse
1980	1894	3807	3662
1990	1589	1727	2807
2000	1470	982	1636
2006	1263	850	927
2007	1316	954	864
2008	1225	903	780
<b>District</b>			
Gurdaspur	2091	587	727
Amritsar	760	919	702



Tarn Taran	1092	691	822
Kapurthala	1813	1460	1457
Jalandhar	923	1386	782
S.B.S. Nagar	6736	2753	670
Hoshiarpur	1110	445	630
Rupnagar	1126	622	898
S.A.S. Nagar	6355	3455	2946
Ludhiana	795	466	394
Ferozpur	1756	920	478
Faridkot	563	350	423
Muktsar	7431	3879	946
Moga	6899	1374	669
Bathinda	1124	1052	2083
Mansa	5714	1549	1050
Sangrur	1733	1555	1967
Barnala	2570	1181	1593
Patiala	610	1593	1168
Fatehgarh Sahib	9383	5754	1271

Source: Government of Punjab, Statistical Abstract 2009 p. 494

Among the communicable diseases, malaria, TB, HIV/AIDS, water-borne infections – Gastroenteritis, Cholera, and some forms of Hepatitis – continue to contribute to a high level of morbidity in the population, even though the mortality rate may have been somewhat moderated (GOI, 2002). ‘Life-style’ diseases - diabetes, cancer and cardiovascular diseases have increased in prevalence and the persistent incidence of macro and micro nutrient deficiencies, especially among women and children “has a multiplier effect through the birth of low birth weight babies and mental and physical retarded growth” (GOI, 2002).

The strong links between poverty and ill health need to be recognised. The onset of a long and expensive illness can drive the poor (and many who may have initially been better off) into poverty. Ill health creates immense stress even among those who are financially secure. High health care costs can lead to entry into or worsening of poverty. The importance of public provisioning of quality health care to enable access to affordable and reliable health services cannot be overestimated in the context of preventing the non-poor from entering into poverty or in terms of reducing the suffering of those who are already below the poverty line.

Declining financial allocations to the health sector must be seen in this context. Reforms induced pressure to cut back public expenditure has led to cuts in public spending on the health sector in particular.

There is a gender dimension to ill-health and care for when chronic illness enters the home, women and girls “find the time to add caring for sick family members to their existing responsibilities in a context where they are already stretched, surviving in conditions of poverty and lack of resources, often themselves sick and in need of care.” Since the tasks are performed arduous tasks of unpaid care are performed gratis, within the home, the contribution is non-monetised and remains statistically invisible. There is an opportunity cost to the time allocated to these tasks as it could have been spent on paid “economic” activities instead.

## **VI. Maternal and Child Health**

Maternal health is nationally and internationally recognized as a major issue. Time-Bound Goals for the Eleventh Five Year Plan include reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births. Maternal mortality in India is unacceptably high at 254 per 100,000 live births on average for India and 192 for Punjab for 2004-06. In comparison, MMR estimates are only 10 for Japan and 56 for China.

Data pertaining to institutional births, and ante and post natal care based on NFHS -1 (1992-93), NFHS-2 (1998-99) and NFHS-3(2005-06) is presented in Table 22 below. A minimum of three antenatal visits are recommended during pregnancy. While the estimate has increased over time, only 50.7 per cent mothers received three antenatal visits for their last birth.

Similarly while institutional births have increased from 26.1 to 40.8 per cent between 1992-93 and 2005-06, almost 60 per cent of births are non-institutional and 51.2 per cent births are not assisted by a health professional or even an ANM. Sharp rural-urban disparities remain. Only 36.8 per cent women receive the recommended post delivery care within two days.

**Table 22: Maternal and Child Health**

<b>Maternity care (for births in the last 3 years)</b>	NFHS-1 (1992-93)	NFHS-2 (1998-99)	NFHS-3 (2005-06)	Urban	Rural
Mothers who had at least 3 antenatal care visits for their last birth (%)	43.9	44.2	50.7	73.8	42.8
Mothers who consumed IFA for 90 days or more when they were pregnant with their last child (%)	na	na	22.3	34.5	18.1
Births assisted by a doctor/nurse/LHV /ANM/other health personnel (%)	33	42.4	48.8	75.3	39.9
Institutional births (%)	26.1	33.6	40.8	69.4	31.1
Mothers who received postnatal care from a doctor/nurse/LHV/ANM/other health personnel within 2 days of delivery for their last birth (%)	na	na	36.8	60.8	28.5
Children 12-23 months fully immunized BCG, measles, and 3 doses each of polio/DPT (%)	35.5	42	43.5	57.6	38.6
Children age 12-35 months who received a vitamin A dose in last 6 months (%)	na	na	24.9	26.8	24.2

Source: NFHS

Referring to the high maternal mortality as a “modern day scandal” Gita Sen<sup>16</sup> (2008) draws attention to the fact that and high MMRs are mainly a problem of the poor. “Millions of women in developing countries are afflicted with short- and long-term illness related to pregnancy and childbirth including fistulae, cervical tears, infections, incontinence, or nerve damage to name a few. More than 40% of the 210 million pregnancies each year result in complications, 15% being life-threatening. The chief causes of maternal deaths – hemorrhage, obstructed labor, unsafe abortion, sepsis, and eclampsia – are well known, but the rate of maternal deaths has fallen only 1% a year during 1990–2005.” Her field work in 60 villages in Koppal district in Karnataka provides evidence that “a major barrier to safe delivery and effective post-natal care in a backward district is insensitivity by health providers to poor, lower caste women. This results in women dying even when there has been no delay in their reaching out for help, in reaching care, or even in getting treatment.

<sup>16</sup> Health inequalities: Gendered puzzles and conundrums. The 10th Annual Sol Levine Lecture on Society and Health, October 6, 2008, published in *Social Science & Medicine* 69 (2009).

Getting treatment is not helpful unless it is effective, but effectiveness is only partly determined by such things as the qualifications and knowledge of the provider. The other part is governed by the extent of the gender, caste, and economic class chasm between providers and patients.” This is a shocking indictment of the public health delivery system and underlines the need for behavioural change.

Arguing that the debate around maternal health policy has focused on the immediate environs of pregnancy – antenatal care, safe delivery, and post-natal care, she points out that this addresses only part of the problem as the “root causes of maternal mortality include the intersections of poverty and gender bias – poor nutrition, anaemia, early marriage and child-bearing, low female educational attainment, domestic violence including violence during pregnancy and unsafe abortion.”

The Eleventh Plan draws attention to the high levels of maternal mortality and points out that these are directly correlated to women’s “lack of access to health care facilities”, discriminatory practices that “deny women access to good nutrition and care” and deliveries without assistance from any health personnel.<sup>17</sup> Additionally, the Eleventh Plan notes that “inaccessibility of health centres and poverty prevent (women) from getting timely medical aid. Absence of toilets and drinking water adversely impacts their health. NFHS-3 data reveals that only 27.9% households in rural areas and 70% in urban areas have access to piped water. Further, only 25.9% households in rural areas have access to toilets.” Together with access to nutritive diets, access to preventive and curative health care, safe drinking water and sanitation within the home, safe disposal of solid waste and hygiene is critical if we are to reduce the levels of mortality and morbidity and reduce drudgery for women. Urgent action is needed if we are to reduce MMR.

While MMR has declined in Punjab, achievement is below target. In addition to budgeting for, planning and enabling rapid expansion of skilled birth attendance and Emergency Obstetric Care many of the “root causes” especially anaemia, safe water, sanitation and domestic violence need to be addressed in Punjab if MMR is to be successfully reduced.

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<sup>17</sup> Planning Commission (2008), *ibid*, p. 186.

## Child Survival and Child Health

NFHS-3 Report for 2005-06 for Punjab estimates infant mortality at 42 deaths before the age of one year per 1,000 live births, compared with the NFHS-2 estimate of 57. The under-five mortality rate for Punjab is 52 deaths per 1,000 live births and this too has declined significantly from the NFHS-2 estimate of 72. The Report notes that “despite declining mortality, more than 1 in 24 children in Punjab still die within the first year of life, and 1 in 19 die before reaching age five.... Further, children whose mothers have no education are more than one and half times as likely to die before their first birthday as children whose mothers have completed at least 10 years of school. After the first month of life and before they are five years old, girls in Punjab face a much higher mortality risk than boys. The child mortality rate by sex shows that the gender differential in mortality is particularly high for children above the age of one year. The child mortality rate for girls is 16 deaths per 1,000 children age 12-59 months, compared with only 6 for boys.” This indicates strong discrimination against the girl child and needs corrective intervention. District level IMR data from Census 1991 and 2001 is presented in Table 23 below. Analysis shows that sharp rural – urban disparities exist and range from a low of 22 for Female IMR in urban Kapurthala to a high of 63 for Female IMR in rural Sangrur and Mansa. While IMR for males (42) is significantly higher than for females (35) in urban Firozpur, the disparity is far greater in urban Hoshiarpur with IMR for females at 37 compared with that for males at 23. Hence, more in-depth analysis is needed to identify and understand why even in 2001:

- i) certain districts such as rural Sangrur have very high IMR for both males and females at 62 and 63 respectively;
- ii) the disparity between male and female IMR is so high in urban Hoshiarpur
- iii) female IMR is higher than male IMR in rural areas of all districts except Gurdaspur and Jalandhar.

**Table 23: District-wise Male and Female Infant Mortality Rate, 1991 and 2001**

	IMR 1991									IMR 2001								
	Total			Rural			Urban			Total			Rural			Urban		
	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F
Gurdaspur	53	55	50	53	56	51	50	55	45	37	38	35	38	39	37	31	32	31
Amritsar	50	48	53	58	57	59	35	32	39	41	40	42	45	43	48	33	31	34
Kapurthala	47	51	43	55	59	50	26	27	24	37	37	36	38	38	38	24	26	22
Jalandhar	54	55	52	68	71	65	29	29	29	36	36	36	49	51	48	27	27	28
Hoshiarpur	63	58	69	67	64	70	40	25	59	46	45	46	49	48	50	31	23	37

Nawanshahr	-	-	-	-	-	-	-	-	-	37	37	37	37	36	38	33	33	33
Rupnagar	55	57	54	61	62	60	36	37	34	32	32	32	34	33	35	27	29	26
FatehgarhSahib	-	-	-	-	-	-	-	-	-	43	42	45	44	42	46	42	42	42
Ludhiana	43	38	47	62	60	64	27	25	28	40	37	42	54	53	55	25	23	26
Moga	-	-	-	-	-	-	-	-	-	41	42	41	42	42	43	37	38	35
Firozpur	58	62	53	62	65	50	45	51	37	47	47	48	49	49	50	39	42	35
Muktsar	-	-	-	-	-	-	-	-	-	48	47	50	51	51	53	38	36	40
Faridkot	53	51	55	54	51	57	49	51	48	45	45	44	50	49	50	36	38	34
Bathinda	52	51	53	55	55	57	39	38	41	50	48	51	52	51	54	38	37	39
Mansa	-	-	-	-	-	-	-	-	-	57	55	59	61	59	63	41	40	41
Sangrur	67	65	68	72	70	75	50	51	48	58	57	58	62	62	63	46	46	47
Patiala	56	51	61	61	56	66	41	36	45	42	42	43	45	45	46	36	35	37
<b>Punjab</b>	54	53	55	61	60	61	37	36	39	43	43	44	47	46	47	38	36	37

Source: Page 42-43, Infant and Child Mortality in India District Level Estimates, Population Foundation of India, 2008, <http://www.popfound.org/Child%20Mortality%20PDF.pdf>

One explanation based on NFHS data is that while full immunisation coverage increased from 35.5 in NFHS-1 to 42 in NFHS-2, it increased only to 43.5 in NFHS-3. This needs attention. Since immunization coverage is higher for mothers with 10 or more years of education, additional efforts in this direction may yield significant positive externalities.

### Malnutrition and Anaemia

Malnourishment levels remain extremely high among India's children. While levels of malnourishment vary between States/UTs, with 42% of the world's underweight children and 31% of its stunted children living in India according to IFPRI, 2010, this is now a global concern. Table 24 shows that only just over half of children weighed in *anganwadis* were of normal weight. Meanwhile, there were sharp disparities between states/UTs in this regard. At the national level, whereas 32.4% and 13.07% of children, respectively, were moderately malnourished (Grades I and II), 0.4% of children were severely malnourished (Grades III and IV). The estimates of Grade I malnourishment in Punjab are 31.87% and are close to the national estimates. 2.88% of children suffered Grade II malnourishment and 0.1% were severely malnourished. The Punjab Chief Minister's speech at the NDC notes that 3,16,000 children out of 11,00,000 children were malnourished.

**Table 24: Nutritional status of children under ICDS by state, 31 December 2009**

State/UT	Total no. weighed	Normal weight (%)	% distribution of children by degree of malnourishment
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			Grade I	Grade II	Grades III and IV (severe)
Andhra Pradesh	5,227,418	50.04	32.29	17.58	0.09
Arunachal Pradesh	59,121	<b>100</b>	0	0	0
Assam	1,886,366	64.47	25.87	9.08	<b>0.58</b>
Bihar	N/A				
Chhattisgarh	1,955,948	<b>46.97</b>	33.82	18.48	<b>0.74</b>
Goa	53,885	62.44	31.21	6.27	0.07
Gujarat	3,525,703	<b>43.13</b>	37.58	18.49	<b>0.8</b>
Haryana	2,048,843	56.09	33.42	10.41	0.09
Himachal Pradesh	428,711	62.72	29.12	8.06	0.11
Jammu and Kashmir	197,577	68.88	25.6	5.47	0.06
Jharkhand	2,324,591	56.43	29.19	13.57	<b>0.81</b>
Karnataka	2,896,331	48.00	35.65	15.99	0.35
Kerala	1,861,742	62.82	29.89	7.24	0.06
Madhya Pradesh	6,805,350	56.14	29.93	13.53	0.41
Maharashtra	7,624,908	62.11	31.73	6.03	0.13
Manipur	190,815	86.17	9.71	3.88	0.24
Meghalaya	184,814	61.67	28.76	9.43	0.15
Mizoram	114,920	73.14	20.7	6.06	0.11
Nagaland	178,277	93.63	5.4	0.89	0.08
Orissa	4,336,917	47.33	37.17	14.69	<b>0.82</b>
Punjab	2,044,221	65.15	31.87	2.88	0.1
Rajasthan	3,909,343	52.69	31.36	15.25	<b>0.7</b>
Sikkim	36,114	82.59	15.56	1.8	0.04
Tamil Nadu	4,034,813	63.53	34.82	1.63	0.02
Tripura	197,995	61.61	30.25	7.82	0.31
Uttar Pradesh	8,400,169	47.34	32.04	20.18	<b>0.45</b>
Uttarakhand	117,259	<b>4.36</b>	2.47	91.06	<b>2.11</b>
West Bengal	5,209,557	50.84	34.81	14.22	<b>0.55</b>
Andaman and Nicobar Islands	21,562	84.36	13.27	0	<b>2.37</b>
Chandigarh	69,660	68.31	30.82	0.49	0.37
Delhi	272,002	50.07	33.62	16.29	0.02
Dadra and Nagar Haveli	14,696	<b>27.69</b>	48.22	23.71	0.37
Daman and Diu	7,663	47.23	42.24	10.48	0.05
Lakshadweep	6,851	61.13	38.01	0.63	0.23
Pondicherry	27,415	60.27	34.15	5.58	0
<b>All India</b>	<b>66,271,55</b>	<b>54.16</b>	<b>32.4</b>	<b>13.07</b>	<b>0.4</b>

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Source: Computed based on MWCD data (<http://wcd.nic.in/>).

NFHS 3 data indicates that obesity is emerging as a major problem in Punjab and 38 per cent of women and 30 per cent of men are overweight or obese. In urban areas of Punjab, close to half of women are overweight or obese. Gupta et al report that in the last seven years, the percentage of women who are overweight or obese has increased from 30 per cent to 38 per cent in Punjab. The extent of overweight and obesity is greater among women than men. According to NFHS data, the extent of underweight children among rural children is higher than that among urban children by almost 10 percentage points.

The percentage of ever-married women who have anaemia is 38 per cent in Punjab and anaemia prevalence among pregnant women is almost 5 percentage points higher than that among all women. A matter of serious concern is increasing anaemia prevalence among pregnant women in the last seven years, and low coverage (less than 35 per cent) of consumption of iron and folic acid for 90 or more days during pregnancy. Men are much less likely than women to be anaemic, but anaemia levels in men are still unacceptably high at 13 per cent in Punjab. The anaemia situation is most serious among young children age 6-35 months.

**Table 25: Nutritional Status of Children and Ever-Married Adults (age 15-49)**

	NFHS-1 (1992-93)	NFHS-2 (1998-99)	NFHS-3 (2005-06)	Urban	Rural
<b>Anaemia among Children</b>					
Children age 6-35 months who are anaemic (%)	na	74.2	78.9	72.2	80.9
Children under 3 years who are stunted (%)	na	51	44.9	37.4	47.2
Children under 3 years who are wasted (%)	na	19.7	22.9	19	24.1
Children under 3 years who are underweight (%)	51.5	42.7	40.4	30.1	43.7
<b>Nutritional Status of Ever-Married Adults (age 15-49)</b>					
Women whose Body Mass Index is below normal (%)	na	36.2	33	19.8	38.8
Men whose Body Mass Index is below normal (%)	na	na	28.1	17.5	33.1
Women who are overweight or obese (%)	na	10.6	14.8	28.9	8.6
Men who are overweight or obese (%)	na	na	12.1	22.2	7.3
Ever-married women age 15-49 who are	na	51.8	56.2	51.5	58.2



anaemic (%)					
Pregnant women age 15-49 who are anaemic (%)	na	49.7	57.9	54.6	59
Ever-married men age 15-49 who are anaemic (%)	na	na	24.3	17.2	27.7

Source: NFHS

In Budget Speech 2010, the Finance Minister stated that:

“Government is committed to universalisation of the Integrated Child Development Services (ICDS) Scheme in the country. By March 2012, all services under ICDS would be extended, with quality, to every child under the age of six.”

However, the ICDS programme cannot deliver the outcomes required of it either for boys or for girls, due to a host of reasons. These include the unsanitary conditions in and lack of regular cleaning of public spaces in slums and *jhuggi jhonpris* (squatter settlements); poor and unsafe water; lack of funds for basic equipment such as toys, weighing scales, charts, medical kits, mats, stationery, brooms, etc., which are inexpensive but important sources of support; overloading ICDS supervisors with overseeing an unrealistically large number of anganwadis that are scattered in terms of geographical coverage leading to poor monitoring; overloading of staff with non-ICDS tasks such as attendance at events organised by political parties; poor supervision owing to non-ICDS-related demands on time; lack of training, skills and motivation of workers and helpers; unrealistically low provision for rents for an anganwadi centre; unrealistically low levels of honorarium for anganwadi workers and helpers; poor quality of supplementary nutrition provided; among other factors.<sup>18</sup>

Gender Responsive Budgeting in the context of the ICDS would require that the Budget take cognizance of each of these factors and ensure corrective mechanisms to translate the phrases such as “inclusion” and “Government is committed to universalisation” that are used by the Finance Minister in his Budget Speech, into outcomes. In addition to universalisation of access ordered by the Supreme Court, this would require that each of the design, convergence, staffing, honorarium etc issues and flaws raised above are addressed and norms and budgets allocated for each component are realistic and adequate. Monitoring, evaluation and corrective action based on follow up and feedback would be needed across spatial units

<sup>18</sup> Aasha Kapur Mehta and Akhtar Ali, (2008) ‘Functioning and Universalisation of the ICDS in Delhi.’ Draft Report submitted to the Government of NCT Delhi.

to determine changes in malnourishment levels for both girls and boys on a regular basis. If girls are not availing of the benefit of the facilities provided then reasons for this would have to be identified and constraints systematically addressed.

## VII. Disease Burden: Gender Issues

Data from the Statistical Abstract for Punjab for 2008 is presented in Table 26 below and shows that in 2008, 1,37,57,716 persons received treatment in the OPD, 5,10,472 persons were admitted for treatment and 9,448 died. The leading cause of death among hospitalised patients was related to problems of the circulatory system, followed by infective and parasitic diseases, diseases of the respiratory system, external causes, injury, poisoning and consequences of external injuries. Together these five diseases account for 70% of deaths among indoor patients.

Respiratory system related diseases are the highest cause of demand for outpatient treatment. Other major causes include abnormal laboratory and clinical finding, skin and sub-coetaneous tissue, digestive system, infective and parasitic disease, blood and blood forming disease, which together account for around 64% of those seeking treatment.

**Table 26: Broad Category-wise Outdoor-Patients, Indoor-Patients Treated and Number of Deaths among Indoor Patients during 2008 in Punjab (P)**

<b>Name of Diseases</b>	<b>Outdoor Patients</b>	<b>Indoor Patients</b>	<b>Number of Deaths</b>
Infective and Parasitic Disease	1129395	62461	1800
Neoplasm	32000	5667	228
Blood and Blood Forming Disease	984225	16408	206
Nutritional and Metabolic Disease	461385	10707	427
Mental Disorders	170436	7749	26
Nervous System	79089	4049	303
Eye and Odnexa	855688	25810	
Ear and Mastoid Process	491161	5296	
Circulatory System	732508	24674	2075
Respiratory System	2379228	31956	1088
Digestive System	1321362	30065	453
Skin and Sub-Cutaneous Tissue	1406230	4856	20
Musculo-Skelton System and Connective Tissue	604396	3422	1
Genito Urinary System	470455	32155	204
Pregnancy Child Birth and Puerperium	212915	55701	54

Prenatal Period	24151	11432	447
Congenital Malformation - Deformation Chromosomal Abnormalities	7973	1173	19
Abnormal Laboratory and Clinical Finding	1609362	47861	421
Injury Poisoning and Consequences of External Injuries	511279	58118	703
External Cause of Morbidity and Mortality	187117	64036	972
Others, Unspecified	87361	6876	1
<b>Total</b>	<b>13757716</b>	<b>510472</b>	<b>9448</b>

Source:- Government of Punjab, Statistical Abstract 2009, p. 489

(P) Provisional

Information regarding health seeking behaviour and disease burden provided in the Statistical Abstract is not presented separately for males and females. This is the first step that needs to be taken to enable analysis from a gender perspective. Before gender gaps in access to treatment can be identified, gender differentials in reported disease burden need to be identified. Gender segregated data that is available for some chronic diseases is dated and is from Sarvekshana (1980). This shows that asthma, high blood pressure, rheumatism, bronchitis, tuberculosis, piles, leprosy, epilepsy, kidney stone or kidney trouble and mental illness were among the chronic diseases suffered by the people of Punjab in both rural and urban areas (Table 27). However, women were more prone to tuberculosis, high blood pressure, rheumatism and ulcers than men in both rural and urban areas. Since blood pressure and ulcers may be caused by stress it will be useful if the data is provided by age and other characteristics as well so that the causal factors can be identified and addressed.

**Table 27: Number of Persons Suffering from Different Types of Chronic Diseases in Punjab by Age, Sex and Residential Status (per 100000 Persons)**

Characteristics	Punjab (Rural)			Punjab (Urban)		
	M	F	P	M	F	P
Tuberculosis	102	130	115	75	107	90
Leprosy	-	-	-	56	65	60
Syphilis	45	22	34	19	21	20
Cancer	13	-	7	-	43	20
Thyroid trouble or Goiter	13	7	10	19	62	40
Diabetes	13	50	30	37	22	30
Mental illness	51	50	51	19	43	30
Epilepsy	70	58	65	37	21	30
Rheumatic fever	26	65	44	-	-	-
High blood pressure	45	123	81	130	215	169
Bronchitis	102	86	95	130	86	110
Asthma	774	468	630	391	407	398

Peptic ulcer	26	72	48	19	43	30
Kidney stone or Kidney trouble	96	72	85	56	-	30
Arthritis	6	14	10	-	22	10
Rheumatism	154	195	173	56	257	149
Stroke	26	14	20	-	-	-
Piles	204	86	149	37	107	70
Others	582	685	630	540	472	508
Not recorded	-	-	-	-	-	-
<b>All types of ailments</b>	2348	2197	2277	1621	1993	1794
No. of sample ailments	367	305	672	87	93	180

**Source:** NSS 28<sup>th</sup> Round, *Sarvekshana*, Volume IV, No. 1& 2, 1980.

It is important to draw attention to the fact that the morbidity rates estimated by the NSS are significantly lower than those collected through micro-studies.

The World Bank World Development Report for 1993 reported that an estimated 766000 girls and women died from tuberculosis in 1990. Using the WHO global estimate of nearly 3 million deaths now due to tuberculosis each year, the number of deaths among females rises to at least 1 million. By comparing these figures to maternal mortality, which is estimated to cause 0.5 million deaths annually, it becomes clear that tuberculosis should be considered a priority women's health concern<sup>19</sup>.

When monitoring disease control programmes such as tuberculosis, it may be important to ask whether the data that is collected, is disaggregated for men and women. How many men and women are treated? How many men and women are reported to suffer from TB? Is there fear of stigma or lack of mobility or difficulty in going to a doctor or primary health care centre? Do some women TB sufferers not get treated because they do not get tested? If more males are treated for tuberculosis than females, is it because relatively more males suffer from tuberculosis or because there is differential treatment seeking behaviour? Detection, treatment and compliance have implications for successful control of TB.

Reviewing the role that socio-economic and cultural factors play in determining gender differentials in tuberculosis (TB) and tuberculosis control, Hudelson (1996) points out that firstly there may be differences in the rates of infection and progression to disease, and

<sup>19</sup> R Hudelson, Gender differentials in tuberculosis: the role of socio-economic and cultural Factors, *Tubercle and Lung Disease* (1996) 77, 391-400

second, they may lead to gender differentials in barriers to detection and successful treatment of TB. Among the factors identified are:

- exposure to tuberculosis bacilli may vary depending on roles and activities;
- rate of progression from infection to disease may depend on health/nutritional status. If women's health is worse than men's risk of disease may increase;
- barriers to early detection and treatment of TB are probably greater for women than for men. Gender differences also exist in rates of compliance with treatment;
- The fear and stigma associated with TB may have a greater impact on women than on men.

TB in women can have serious repercussions for families and households. Detection, treatment and compliance have implications for successful control of TB.

Hudelson points out that approximately one-third of the world's population are infected with *Mycobacterium tuberculosis*. Based on the cumulative experience of PPD skin test surveys the researcher points out that in most situations while the prevalence of infection is higher in men than in women, while the annual risk of infection and the cumulative prevalence of infection is higher in young men than women, the incidence of clinical disease is equal or even greater in women. Citing Kutzin World Bank (1993) community-based study in India comparing the health of women and men in the same household, Hudelson draws attention to the finding that women suffered a higher rate of morbidity but used health services less.

## **VIII. Domestic Violence**

The most serious aspect of gender discrimination that confronts us however, is violence against women, one manifestation of which is the alarmingly low female-male sex ratio. Special cognisance needs to be taken of this problem and actions taken to put a stop to violence against women and the girl child. Deosthali, Magnani and Malik<sup>20</sup> (2005) point out that there are many forms of gender-based violence and these include “sex-selective abortion, incest, trafficking, marital rape and other forms of sexual assault, sexual harassment in the workplace, forced suicide, honour killings, dowry-related homicide, and various forms of physical and emotional abuse perpetrated by intimate partners” and each of these forms of violence “impacts women’s health in myriad ways—both directly and indirectly—and can

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<sup>20</sup> Padma Deosthali, Purnima Maghnani and Seema Malik, *Establishing Dilaasa: Documenting the Challenges*, Cehat, Mumbai, 2005

lead to chronic debilitating conditions and even death.” Spousal violence can have serious health related consequences that range from fatality to physical injuries, inflammation, abortion and psychological disorders and some of these are listed in Box 2.

**Box 2: Health consequences of intimate partner violence and sexual violence by any perpetrator**

Fatal outcomes	Nonfatal outcomes		
	Physical injuries and chronic conditions	Sexual and reproductive sequelae	Psychological and behavioral outcomes
Femicide Suicide AIDS-related mortality Maternal mortality	Fractures Abdominal/thoracic injuries Chronic pain syndromes Fibromyalgia Permanent disability Gastrointestinal disorders Irritable bowel syndrome Lacerations and abrasions Ocular damage Burns Ear Injuries	Gynecological disorders Pelvic Inflammatory disease Sexually-transmitted infections, including HIV Unwanted pregnancy Pregnancy complications Miscarriage / low birth weight Sexual dysfunction Unsafe abortion	Depression and anxiety Eating and sleep disorders Drug and alcohol abuse Phobias and panic disorder Poor self-esteem Post-traumatic stress disorder Psychosomatic disorders Self harm Unsafe sexual behavior

Sources: Prepared for Violence against Women: Health Sector Responses, World Bank PREM Group, adapted from Heise and Garcia Moreno, 2002 (pg 101); and Heise, Ellsberg and Gottemoeller, 1999 (pg 18). Available at: <http://siteresources.worldbank.org/INTGENDER/Resources/Health.pdf>

A substantial proportion of married women have been abused, physically or sexually, by their husbands at some point of time in their lives<sup>21</sup>. As many as 1 out of 4 married women reported that they had experienced physical or sexual violence from their husband in the 12 months prior to the NFHS-3 survey. Most women did not seek help when they were abused. Only 1 in 4 abused women have ever sought help to end the violence and 66% of abused

<sup>21</sup> Kamla Gupta, Sulabha Parasuraman, P Arokiasamy, S K Singh and H Lhungdim, Preliminary Findings from the Third National Family Health Survey Vol. 41 No. 42, October 21 - October 27, 2006

women not only have not sought help but they have also not told anyone about the violence. One – third of women in the age group 15-49 have experienced physical violence.

The prevalence of spousal abuse is high in Punjab at 37.2 per cent (Table 28) and as many as 46.4 per cent of uneducated women are likely to have suffered spousal violence. However, spousal abuse even extends to women who have completed ten years or more of education (16.3 per cent of whom have been victims of spousal violence).

**Table 28: Ever-married women who have experienced spousal violence (per cent)**

	NFHS (2005-06)	Residence		Education			
		Urban	Rural	No Education <sup>4</sup>	< 5 years complete <sup>4</sup>	5-9 years complete <sup>4</sup>	10 years complete and above <sup>4</sup>
Ever-married women who have ever experienced spousal violence	37.2	30.4	40.2	46.4	42	32.4	16.3

Source: NFHS

Until a few years ago, State agencies and even the police considered it inappropriate to interfere in cases of spousal and domestic violence. With the enactment of the Protection of Women from Domestic Violence Act on 26th October 2006, the State is responsible for providing protection to women who suffer domestic violence. However, before the accused is convicted, a complaint needs to be made. Only a fraction of those who suffer from domestic violence register a complaint. What are the mechanisms through which the State can reach out and provide support? If the objective is that the suffering of victims of domestic violence be reduced then effective implementation of the Domestic Violence Act is key to achieving this objective.

The Report of the Working Group on Empowerment of Women for the 11<sup>th</sup> Plan required that the following be taken up in the Eleventh Plan:

- Set up the required infrastructure and requirements to make the Act effective.
- Provide training, sensitization and capacity building of Protection Officers, Service Providers, members of the judiciary, police, medical professionals, counselors, lawyers, etc on the issue of domestic violence and the use of law (PWDVA and other criminal and civil laws) to redress the same.

- Monitor the appointment of Protection Officers by regular feedback from the various states
- Set up an effective MIS to monitor its implementation.
- Give wide publicity to the Act.
- Rs.500 crore was proposed to be provided for implementation of PWDVA in the XI Plan.

Eleventh Plan (Vol 2) notes that under the Eleventh Plan Budgetary allocations will be made for effective implementation of the legislation through providing adequate publicity; creating the required infrastructure; appointment of Protection Officers and setting up district-level cells to be responsible for monitoring and implementation of Protection of Women from Domestic Violence Act (PWDVA) and other Acts under its charge.

While the Act has been passed, it must not remain limited to words that do not get translated into action. For action, adequate funds must be allocated to implement the words. Are the allocations adequate? Do the heads against which allocations are made meet the needs of victims of domestic violence? The budget allocated and the norms on which it is based are critical to successful implementation of the DV Act.

Budget requirements depend on the needs of the woman who suffers domestic violence.

These include:

- Counselling regarding her rights under the DV Act and protection within the home so violence does not recur;
- Support for her within the home so that her daily needs are met;
- Medical help, treatment and support if needed.
- Counselling for mental health;
- The public health system is a critical entry point for implementation of anti-domestic violence intervention and the *Dilaasa* model can be adopted to set up successful partnerships between the medical system and NGOs working on health issues to provide care;
- Legal counselling and help if she wants to take the case to court;
- Shelter and protection if she wants to leave the home;
- Information regarding the point of contact for the woman who suffers domestic violence;
- Appointment of Protection Officers with norms regarding the distance at which the Protection Officer will be located so as to provide access for a woman living in a village or a slum;
- Salary of the Protection Officer, office space and other support and facilities.



Among the Stakeholders for Successful Implementation of the DV Act are the Woman affected by Domestic Violence; Government, State Governments, MWCD and other departments; Protection Officers; NGOs and other Service Providers; Police Officers; Judiciary; Legal Aid and counselling providers; Medical care and mental health counselling; Shelter Home for shelter, safety, food, clothing, transport, monetary and other support; and concerned civil society groups. There may be funding needs of each of these stakeholders. How are they to be met?

To understand Budgetary Allocations in PWDVA, CBGA filed RTIs in several states to determine the budgetary allocation and break up into heads and subheads for the implementation of the Domestic Violence Act; the basis for this budgetary allocation and requested copies of the budget and expenditure incurred for the 2008-2009 for implementation of the Domestic Violence Act. They found that different states had allocated different amounts for implementation of the DV Act that ranged from a few lakhs to several crore. For instance, the amounts allocated were:

- Madhya Pradesh: Rs. 2.92 crore/ Rs 2.5 crore
- Karnataka: Rs. 1.50 crore/ 2.92 crore
- Kerala: Rs 1 crore/ Rs 2.92 crore
- Andhra Pradesh: Rs. 99 lakhs/ Rs 98 lakhs
- Tamil Nadu: 98 Lakh for 30 Districts
- Delhi: Rs. 5 Lakh / 22 lakhs
- Sikkim: Rs. 10 Lakh / 8 lakh

The amount utilised out of the budgeted amount varied sharply between States – from full or 100 percent utilisation to 0 utilisation. Andhra Pradesh, Haryana, Assam, Meghalaya and West Bengal were able to utilise the allocated amount. In Delhi, Karnataka and Tamil Nadu, utilisation dipped in 2009-10. In Kerala included Domestic Violence under Gender Awareness programme. Madhya Pradesh had poor utilisation in both years. While Punjab had budgeted Rs 50 lakhs in 2008-09 and 2009-10, the amount utilized was nil (see Table 29).

**Table 29: Budgeted and Actual Expenditure on Implementation of the Domestic Violence Act**

State	2008-09	2008-09	AE as % of BE	2009-10	2009-10
	<b>BE</b>	<b>Expenditure</b>		<b>BE</b>	<b>Expenditure</b>
Andhra Pradesh	9982000	9960000	99.78	9840000	9840000
Assam	1000	0		8400000	8400000
Delhi	500000	404934	80.99	2200000	600000
Haryana	2500000	2372000	94.88	8000000	NA
Karnataka	15000000	14662000	97.75	29234000	10976000
Kerala	10000000	9997990	99.98		
Madhya Pradesh	29200000	10876000	37.5	25000000	8530000
Meghalaya	320000	320000	100.00	350000	350000
Orissa	0	0		0	0
Punjab	5000000	0		5000000	0
Sikkim	1000000	51000	5.10	800000	600000
Tamil Nadu	9754653	9754653	100.00	8490000	2596000
Uttarakhand	5000000	0	0.00	5000000	0
West Bengal	2631520	2631520	100.00	3215000	Upto Feb' 2620000

Source: Information provided by CBGA for a presentation made at the NCW-Lawyers Collective Seminar on Staying Alive: Fourth National Conference on the Implementation of Protection of Women from Domestic Violence Act, 2005, December 19, 2010 at India Habitat Centre

It needs to be noted that:

- 14 States have made a separate allocation for implementation of the DV Act;
- Orissa did not have a separate head for implementation of the DV Act till 2009 and has added this in 2010?
- Allocation in Karnataka has increased for 2010-11 as they plan to appoint regular independent Protection Officers;
- However, Arunachal, Bihar, Chhattisgarh, Goa, Jharkhand, Mizoram, Rajasthan and UP have not made even ad hoc allocations for various components of the DV Act;
- Gujarat, Himachal, Maharashtra and Nagaland do not have a separate budgetary allocation for implementation but have spent some amounts for awareness generation and training.

Different States allocated different amounts for expenditure under various heads:

- For Protection Officer and assistant salaries Tamil Nadu allocated 78 lakh;
- for Protection Officer Training Tamil Nadu allocated 4 lakh.
- Travel allowance – 11.5 lakh (Andhra Pradesh)
- Material and supplies – 10 lakh (Andhra Pradesh)
- Contractual services – 83 lakh (Andhra Pradesh) these include data entry operators, assistants, counselors, messengers
- Advertising and Publicity

- Hiring vehicles for Protection Officers (Kerala)
- Orientation and Training for Legal Counsellors (Kerala)
- Stationery for Protection Officers (Kerala)
- Written test for women Protection Officers (Kerala)
- District wise Sensitisation and Seminars
- Honorarium for Legal and Medical Counsellors
- Computers - 15.5 lakh (Tamil Nadu)

Additionally it is relevant to examine who should be appointed as a Protection Officer and whether this should be a full time or part time post; a contract appointment or government officer. CDPOs have several tasks to complete already for the ICDS. In some States CDPOs have additionally been appointed as Protection Officers. Is it possible for the CDPO to undertake this task in addition to all her other duties? Norms regarding the number of married women for whom a Protection Officer should provide coverage must be determined and followed. Issues of education and training required for the post need to be addressed as also who will provide this training. Each of these issues has budgetary implications as do decisions regarding budget requirements for meeting the needs of the woman who does not want to stay with the family and whether she should be lodged in an existing shelter; funds for meeting her needs for food, soap, clothes, bed, doctor, legal, counselling needs, travel needs, contingencies etc. Budgetary provisions must be made for this if the Act is to be implemented with sincerity.

**Box 3: Lessons from *Dilaasa*: Can such crisis centres be established in hospitals in Punjab?**

*Dilaasa*, Crisis Centre for Women is the first hospital-based crisis centre in India that is designed to respond to the needs of women facing violence within their homes through sensitising the public health system to domestic violence. The Centre is a joint initiative of the Public Health Department of the Brihanmumbai Municipal Corporation (BMC) and the Centre for Enquiry into Health and Allied Themes (CEHAT), a Mumbai-based multi-disciplinary non-governmental institution promoting and supporting socially-relevant health and related research, action, services, and advocacy. *Dilaasa* is located in K B Bhabha Hospital, which is one of the 16 peripheral general hospitals of the BMC.

The goal is to:

- i) institutionalise domestic violence (and violence against women) as a legitimate and critical public health concern within the government hospital system, and

ii) build the capacity of hospital staff and systems to adequately, sensitively and appropriately respond to the health needs of the victims and survivors of domestic violence.

While the serious health consequences of domestic violence for women are well researched and established, the role of the public health system in responding to the issue has not received adequate attention. The public health system is an important site for the implementation of anti-domestic violence intervention programmes for a number of reasons.

- 1) the health care system is often the first contact for victims and survivors, who approach health care providers for treatment;
- 2) the public health system is the only institution that can produce medical and forensic evidence formally recognised by the criminal justice system (eg register medico legal cases).
- 3) women are more likely to share the actual cause of injury with a doctor
- 4) the health care system provides a place where gender and violence sensitisation programmes targeting the general public, health care providers, administrators, policy makers, and project developers can be carried out.
- 5) However, medical professionals are not adequately equipped to sensitively respond to the issue of violence against women. Systematic efforts are needed to sensitise health care professionals to this issue and to the critical role they can play in screening, documentation, treatment and referral.

Hence, the collaboration between CEHAT and the BMC is significant as no NGO can reach out to as many women as can a public hospital. Creating a space in a public hospital makes it safe and accessible to women and encourages the state to respond to domestic violence. Location of the crisis centre in a public hospital helps project domestic violence as a public health issue. The project has been conceptualised and implemented as a joint project—in terms of human resources, leadership and management. The *Dilaasa* project team comprises professionals from both CEHAT and the public hospital system. The specific roles and responsibilities of both of the partner organizations have been clearly delineated in the Memorandum of Understanding.

Three large rooms close to the Casualty have been provided free of charge for use for counselling, legal aid, documentation and training. Two rooms for the crisis centre work are on the ground floor of the hospital opposite the casualty department and one is on the third floor for training and documentation. The conference hall is available for conducting training.

In addition to training hospital staff to recognize symptoms of domestic violence the *Dilaasa* Crisis Centre provides emotional support to women and gives them detailed information about the Protection of Women from Domestic Violence (PWDV) Act and laws related to custody, divorce, maintenance and provision of section 498A of the Indian Penal Code and the implications of such action. Those who opt for legal action are connected with a lawyer. The most frequent legal assistance needed by women involves the processing of an injunction order, petitioning for maintenance and, occasionally, filing for divorce.

Group counseling is facilitated through referrals and escort services to organisations that facilitate such group meetings. Women are also given information about available skill building courses, trusts providing monetary relief for educational and health purposes and are referred to relevant agencies for social support. *Dilaasa* also provides temporary shelter at two shelters in Mumbai as well as a 24-hour shelter under medical observation at the hospital. Hospital staff are trained to recognize symptoms of domestic violence and capacity building conducted for staff of other hospitals, who once trained could not only screen women for domestic violence but also provide referrals to centers close by. “Training of trainers” at 5 hospitals was conducted by trained hospital staff with support from CEHAT staff so as to develop an understanding of domestic violence as a healthcare issue and role of healthcare providers in responding to patients; and to build skills in screening women for domestic violence and provide an understanding about the cycle of violence and specific needs of women who suffer domestic violence. A training cell was formed to share resources and experiences of health care professionals.

Source: Deosthali, Maghnani and Malik op.cit.

## **IX. Summary, Conclusions and Recommendations: Issues needing attention for Gender Responsive Budgeting in Health in Punjab**

The Budget is an instrument for fulfilling the obligations of the state and a political statement of the priorities set by the Government in allocating resources. Gender Responsive Budgets are not separate budgets for women or for men. The purpose of Gender Responsive Budgeting is to achieve gender-just allocations and outcomes of all public expenditure. This cannot be achieved unless the needs and priorities of women, especially those who are poor;

are identified; unmet needs are met; budgetary allocations reprioritized so that they are adequate for meeting those needs; and requisite follow-up actions taken to ensure that desired outcomes are attained. Gender Responsive Budgeting in the Health sector is urgently required as the strong links between ill-health and poverty and now well established. While poverty and ill health affect both men and women, the problems get compounded for women as they lack of access to and control over resources and decision making lead to lower levels of access to health care services; high levels of anaemia due to poor nutrition; high care burden; and delayed access to treatment leading to higher levels of mortality.

When women decide how to spend the household budget, however small or large this budget may be, they give the highest priority to providing nutritious food for the family and health care for family members who are ill among other expenditures. Women's priorities with regard to health need to get reflected in National and State Budgets. In 1987 Punjab allocated 10.52% of its total expenditure to healthcare. Only two other states in India, Himachal Pradesh and Nagaland, had allocated higher proportions of their total expenditure to healthcare, with allocations of 13.5% and 10.88% respectively. By 1998 the share of expenditure allocated to healthcare in Punjab had halved to 4.93% and then declined further till it reached 3.10% in 2005. During the period from 2006-07 to 2009-10, Health and Family Welfare account for only 3.25 to 3.80 per cent of the total Revenue Expenditure of Punjab and is less than one-third to one-fourth of the allocation to Education, Sports, Art and Culture. In the same vein, Plan allocations provide 1.40 per cent of total Plan outlay to medical and public health, with individual annual plan allocations varying between 0.64 and 1.98 per cent.

As pointed out in Section IV, per capita health expenditure in Punjab in 2001-02 was Rs 1,530 and was third highest in India. However, public expenditure was only 16.8 per cent per cent of this and this was less than half the 37.8 per cent spent by the State in Himachal Pradesh. Further, average medical expenditure for treatment in Punjab is highest of all States in urban areas at Rs 6051/- due to relatively high charges for Doctor's fee and medicine and fifth highest at Rs 2449/- in rural areas based on estimates provided by the NSS 60<sup>th</sup> Round. Costs in rural areas of Punjab are 10 times higher than costs estimated for rural Tamil Nadu

and two times higher than for rural India. This has serious consequences for the cost of health care and out of pocket expenses leading to health burden on citizens and leads to debt and/or denial of access to healthcare especially to those who are poor and especially women in poor households. As noted in Section IV, over 40% of total credit acquired by marginal and small farmers in Punjab was for healthcare purposes. High costs of medical care are a barrier to access to healthcare for the poor and especially for women among disadvantaged groups.

Estimates of rural population served by each PHC and CHC presented in Section V reflect significant deviation from norms in most districts of Punjab. While the population served per doctor and para medical staff has improved in Punjab between 1980 and 2008, spatial disparities in access to medical care are evident.

In view of the above, Gender Responsive Budgeting requires that we recognise that medical infrastructure and medical staff need to be strengthened on priority; that the financial allocations to the health sector are very inadequate; gaps between allocation and requirement estimated based on deviations from norms; and that budgetary allocations are reprioritised so that funds required for meeting these norms are mobilized and the allocations for Healthcare in the State Budget and in the Plan are increased significantly and adequately.

While budgetary allocations are critically needed to achieve universal high quality healthcare, several other steps need to be taken to attain gender-just outcomes in health. Some of these are discussed below.

As noted in Section III, there are biological differences in the reactions of men and women to medication, anesthesia, and antibiotics and in their immunity to disease. However, socio-cultural behavior patterns, roles, responsibilities, expectations and access to and control over resources add layers to these biological differences. Women and men do not receive the same care, even for the same conditions. The low female-male sex-ratios are evidence of the existence of the missing girl child and reflection of rampant gender bias. Violence is a major public health issue and women are significantly more likely to be victims of sexual assault. Society demands unpaid care work from women within the home but fails to recognize the

value of this work even though it saves the public health system considerable cost. At minimum, the public health system should make efforts to value the work done by caregivers and provide advice and support and reduce drudgery and trauma suffered by them. Gender Responsive Budgeting requires:

- Identification of the existing bias in medical education, medical research, attitude of care providers and health service provisioning;
- corrective action to remove these biases in medical education, medical research and attitude of care providers at all levels;
- provisioning for health care based on understanding of differences between men and women in disease burden and needs;
- explicit integration of gender equity in policies and programmes pertaining to health care;
- recognition and support for the work done by caregivers, provision of advice and reduction of drudgery and trauma suffered by them.
- continuous tracking the sex ratio and taking steps to implement the PNDT Act, prevent female foeticide and infanticide
- efforts to change mind-sets and create a safe and conducive environment for and survival and growth of the girl child
- allocation of adequate budgets to deliver equitable health care of high quality.

In rural areas of Punjab, chronic morbidity among females was higher than males in the age groups 0-14, 15-24 and especially in age group 25-44. Chronic morbidity among women relative to men declined in rural areas after the age of 45. In comparison in urban areas chronic morbidity among females was significantly higher than among men in the age groups 15-24, 25-44 and 45-59 and lower among the very young and old. As pointed out in section III, even though women in India report more illness than men, hospital records show that men receive more treatment. Possible explanations include issues of access, affordability, adequacy and friendliness of health and social infrastructure for meeting women's needs; restricted mobility, income and time burden; and stigma, discrimination and lack of control over health budgets.

Based on the evidence provided above it can be concluded that reported morbidity and chronic morbidity is relatively higher in Punjab and health related issues need priority attention. While all health issues need to be addressed, Gender Budgeting would require the Health Department to identify:



- the reasons for higher prevalence of chronic morbidity among females in age groups 0-14, 15-24 and especially in age group 25-44 in rural areas and among males in age groups 45-59 and above 60 in rural areas.
- the reasons for higher prevalence of chronic morbidity among females in age groups 15-24, 25-44 and 45-59 and among males in age groups 0-14 and above 60 in urban areas.
- collect data to see if these trends have persisted over time or have changed.
- collect data to see if these trends occur across all districts or are peculiar to specific districts.
- address the causal factors in each case.
- Determine why despite reported morbidity being higher among women than men, this is not reflected in access to treatment.

Information regarding health seeking behaviour and disease burden provided in the Statistical Abstract for Punjab is not presented separately for males and females. This is the first step that needs to be taken to enable analysis from a gender perspective. Before gender gaps in access to treatment can be identified, gender differentials in reported disease burden need to be identified. Gender segregated data that is available for some chronic diseases is dated and is from Sarvekshana (1980). This shows that asthma, high blood pressure, rheumatism, bronchitis, tuberculosis, piles, leprosy, epilepsy, kidney stone or kidney trouble and mental illness were among the chronic diseases suffered by the people of Punjab in both rural and urban areas. However, women were more prone to tuberculosis, high blood pressure, rheumatism and ulcers than men in both rural and urban areas. Since blood pressure and ulcers may be caused by stress it will be useful if the data is provided by age and other characteristics as well so that the causal factors can be identified and addressed.

It is also important to draw attention to the fact that the morbidity rates estimated by the NSS are significantly lower than those collected through micro-studies.

When monitoring disease control programmes such as tuberculosis, it may be important to ask whether the data that is collected, is disaggregated for men and women. How many men and women are treated? How many men and women are reported to suffer from TB? Is there fear of stigma or lack of mobility or difficulty in going to a doctor or primary health care centre? Do some women TB sufferers not get treated because they do not get tested? If more males are treated for tuberculosis than females, is it because relatively more males suffer

from tuberculosis or because there is differential treatment seeking behaviour? Detection, treatment and compliance have implications for successful control of TB.

MMR has declined in Punjab but achievement is below target. Section VI shows that while institutional births have increased from 26.1 to 40.8 per cent between 1992-93 and 2005-06, almost 60 per cent of births are non-institutional and 51.2 per cent births are not assisted by a health professional or even an ANM. Sharp rural-urban disparities remain. Only 50.7 per cent mothers received three antenatal visits for their last birth and 36.8 per cent women receive the recommended post delivery care within two days. High levels of maternal mortality are directly correlated to women's "lack of access to health care facilities", discriminatory practices that "deny women access to good nutrition and care" and deliveries without assistance from any health personnel. Absence of toilets and drinking water adversely impacts their health. Access to safe drinking water and sanitation within the home and safe disposal of solid waste and hygiene are critical if the required outcomes are to be achieved. In addition to budgeting for, planning and enabling rapid expansion of skilled birth attendance and Emergency Obstetric Care many of the "root causes" especially anaemia, safe water, sanitation and domestic violence need to be addressed in Punjab if MMR is to be successfully reduced. Clearly, achievement of the targeted outcomes is dependent on actions that extend beyond the boundaries of the Health Department. Gender Responsive Budgeting requires convergence across different departments, tracking progress and a multi-pronged approach for successfully achieving a significant reduction in the MMR.

Despite declining mortality, more than 1 in 24 children in Punjab still die within the first year of life, and 1 in 19 die before reaching age five. The gender differential in mortality is particularly high and indicates strong discrimination against the girl child. Sharp rural – urban and inter-district disparities exist with regard to the IMR, which ranges from a low of 22 for Female IMR in urban Kapurthala to a high of 63 for Female IMR in rural Sangrur and Mansa. Obesity is emerging as a major problem in Punjab and 38 per cent of women and 30 per cent of men are overweight or obese. Increasing prevalence of anaemia among women, pregnant women men and children are cause for concern. All these issues need further analysis, spatial and gender disaggregated mapping and corrective interventions.

The most serious aspect of gender discrimination that confronts us however, is violence against women, which has many forms (described in Section VII), each of which can have serious health related consequences that range from fatality to physical injuries, inflammation, abortion and psychological disorders. Prevalence of spousal abuse is high in Punjab at 37.2 per cent. With the enactment of the Protection of Women from Domestic Violence Act on 26th October 2006, the State is responsible for providing protection to women who suffer domestic violence. While the Act has been passed, it must not remain limited to words that do not get translated into action. For action, systems must be put in place and adequate funds must be allocated to implement the words. Are the allocations adequate? Do the heads against which allocations are made meet the needs of victims of domestic violence? The budget allocated and the norms on which it is based are critical to successful implementation of the DV Act.

Budget requirements depend on the needs of the woman who suffers domestic violence.

These needs include:

- Counselling regarding her rights under the DV Act and protection within the home so violence does not recur;
- Support for her within the home so that her daily needs are met;
- Medical help, treatment and support if needed.
- Counselling for mental health;
- The public health system is a critical entry point for implementation of anti-domestic violence intervention and the *Dilaasa* model can be adopted to set up successful partnerships between the medical system and NGOs working on health issues to provide care;
- Legal counselling and help if she wants to take the case to court;
- Shelter and protection if she wants to leave the home;
- Information regarding the point of contact for the woman who suffers domestic violence;
- Appointment of Protection Officers with norms regarding the distance at which the Protection Officer will be located so as to provide access for a woman living in a village or a slum;
- Salary of the Protection Officer, office space and other support and facilities.

Among the Stakeholders for Successful Implementation of the DV Act are the woman affected by Domestic Violence; the Union Government, State Governments, the Ministry and departments of Women and Child Development; the Health Ministry and Department and State run hospitals, medical care providers and mental health counsellors; other departments;

Protection Officers; NGOs and other Service Providers; Police Officers; Judiciary; Legal Aid and counselling providers; Shelter Home for shelter, safety, food, clothing, transport, monetary and other support; and concerned civil society groups. There will be funding needs of each of these stakeholders and these need to be addressed. However, as pointed out in Section VIII, while Punjab had budgeted Rs 50 lakhs in 2008-09 and 2009-10, the amount utilized was nil so clearly, addressing budgetary allocations and constraints is one major issue to which attention is being drawn through Gender Responsive Budgeting. Identifying the health related needs and priorities of women; putting in place the infrastructure, personnel, institutions, processes and monitoring systems to meet these needs; and getting convergence across departments and stakeholders are equally critical to the achievement of gender-just health outcomes.