An Overview of Policies on Gender Integration for Women Healthcare Providers in India

Summary of Findings

Introduction

For women healthcare providers to have equal opportunities, and to ensure gender equity in the health system, it is imperative that the policies in place in that system are responsive to their needs. To assess the degree to which this is the case in the Indian health system this note provides a broad (though not exhaustive) overview of the available policy provisions relating to women healthcare providers in India, covering the following areas: (i) remuneration and allowances; (ii) career progression; (iii) sexual harassment and violence, and grievance redressal; (iv) maternity and other benefits; (v) staffing and working conditions; and (vi) the retention of women healthcare providers in rural areas. For each area, we describe the policies and provisions available, the adequacy of these provisions, the gaps in terms of their actual implementation, and the potential scope for reforms to improve them so that they match international conventions and benchmarks.

Method

The policy overview was based entirely on desk-based research and drew on issues highlighted in literature, and by experts interviewed on policies related to women healthcare providers in India. For desk-based research web search engines like Google and electronic databases like Google Scholar and Lexis Advance were used. The search terms list included key words from the issues listed in the other document like 'nurse remuneration', specific legal acts like 'Prevention of Sexual Harassment', and known provisions, such as 'maternity leave' etc.

The literature review for this policy overview included policy documents, government reports, guidelines, circulars, legislation, and office orders/notifications, and international conventions and polices, especially the ILO Convention for Decent Work primarily as a guide to desirable standards and potential policy reform.

Findings: Overview of policies and provisions, and gaps

1. Renumeration and allowances

In a context in which women healthcare workers earn 38% less than men the issue of the gender pay gap and poor remuneration for women healthcare workers is of prime concern.

- **National Policies and provisions**

In regard to government nurses (including Auxiliary Nurse Midwives (ANMs)), their remuneration remains at the level set by the 6th Central Pay Commission (CPC) of 2008, as the 7th CPC in 2017 did not significantly revise the salaries of government nurses. For private nurses, remuneration is significantly lower than that of government nurses, with

some being paid less than Indian rupees (INR) 10,000 per month, despite the recommendation by a committee headed by the Director General of Health Services of a minimum salary of INR 20,000 for private nurses. In regard to community health volunteers (i.e. Accredited Social Health Activists (ASHAs)), these are volunteers and thus not subject to government pay scales, but they receive task-/activity-based incentives under the National Health Mission (NHM), varying depending on the state/union territory (UT). Nevertheless, ASHAs receive none of the allowances available to nurses and ANMs (e.g. field allowance, nursing allowance, unform and washing allowance).

While the Government of India has chosen to implement the recommendations of the 7th CPC regarding minor increases in salaries and a field allowance, states have not yet implemented these recommendations.

Gaps

- Lack of implementation of the 7th CPC remuneration standards.
- Lack of provisions for important allowances (e.g. conveyance allowance, professional update allowance).
- Lack of implementation of the minimum remuneration recommendation of the committee headed by the Director General of Health Services.

2. Workplace harassment and violence

Sexual and other forms of harassment and violence perpetrated against women healthcare providers is a problem that is known to be widely prevalent in India, as in other low- and middle-income countries.

- #### National Policies and provisions

The Sexual Harassment of Women at Workplace (Prevention, Prohibition, Redressal) Act 2013 (also known as the Prevention of Sexual Harassment (POSH) Act) provides for the establishment of Internal Complaints Committees (ICCs) to receive complaints regarding sexual harassment, for employers with more than 10 employees, and of Local Complaints Committees (LCCs) at the district level to deal with complaints where there are less than 10 workers, or complaints against the employer himself. However, despite this legal stipulation, many workplaces have yet to constitute ICCs, and some states have not even notified District Officers about the act. While the Department of Women and Child Development in every state/UT is responsible for the overall monitoring and review of POSH, to date no monitoring report has been made public.

Other sexual and workplace harassment grievance redressal mechanisms also exist, including the Sexual Harassment Electronic Box (SHe-Box), an online portal for the registration of complaints related to sexual harassment, the Grievance Redressal Cell set up by the Trained Nurses' Association of India (TNAI) for registered nurses for various grievances (including sexual harassment), the helpline for healthcare providers set up by states to address the grievances of healthcare workers during the COVID-19 pandemic, the Complaint and Investigation Cell set up by the National Commission for Women (NCW) for any case involving the deprivation of women's rights, and district-level grievance redressal committees for ASHAs under the National Rural Health Mission (NRHM).

- #### International provisions

There are three major policies at the international level that India can look to to guide reforms in this area: Target 5.2 of Sustainable Development Goal (SDG) 5 aims to eliminate all forms of violence against all women and girls, in both the public and private spheres. International Labour Organization (ILO) Violence and Harassment Convention 2019 (No. 190) covers many areas not yet implemented in India, including the protection of individuals'

privacy and confidentiality in handling sexual harassment incidents, the right to resign with compensation in the case of harassment, and the provision of support to victims (e.g. medical care and treatment, and help to re-enter the labour market). Finally, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) covers important areas not implemented in India, including the need to change social and cultural norms.

Gaps

- Lack of grievance redressal mechanisms for healthcare providers in healthcare facilities, for issues other than sexual harassment.
- Failure to implement the POSH Act 2013 in states.
- Lack of support to victims (compensation, right to resign, medical treatment, support to re-enter the labour market).
- Lack of strong procedures to ensure privacy and confidentiality in the process of inquiring into incidents of harassment and violence.
- Lack of provisions to ensure a change in social and cultural norms.

3. Maternity benefits

In light of their dual responsibilities (their reproductive role, coupled with their working responsibilities) women healthcare workers require maternity benefits. However, in India these are not always made available, and this can lead female healthcare workers to seek temporary leave and career breaks so they can engage in childcare, adversely affecting their careers.

• National provision and policies

The Code on Social Security 2020 is the key national policy providing for maternity benefits. For women working in certain establishments, including hospitals, it provides for the following: maternity leave of 26 weeks; a medical bonus of INR 3,500 to cover pregnancy and post-partum care costs; and availability of crèches within a prescribed distance (for establishments with >50 employees). Not all of these are implemented (despite being legally binding): for example, on crèches, only two states (Karnataka and Tamil Nadu), have announced rules in this area, while Haryana has drafted rules but has not announced them.

Other important policies include the Working Group on the NRHM, which assures maternity entitlements for all women employees, and the Ministry of Women and Child Development Guidelines, which propose to extend crèche facilities to all employees, including temporary, daily wage, consultants, and contractual personnel.

• International provisions

There are two major policies at the international level that India can look to to guide reforms in the area of maternity benefits: the ILO Nursing Personnel Recommendation (R157) 1977 recognises the need to protect women during the pregnancy period by avoiding nightshifts and work involving hard labour etc., which is currently not mentioned in the maternity provisions in India. The ILO Maternity Protection Recommendation (R191) 2000 mandates leave for employed fathers in the case of the death/hospitalisation of the mother, which again is missing from legislation in India. Evidence shows that paternity leave can lead to a more gender-equitable division of labour.

Gaps

- Lack of a proper implementation mechanism for the establishment of crèches.
- No provision for paternity leave.
- Lack of a provision on re-joining the workforce in the case of a career break.

4. Career progression

Career progression is essential to ensure female healthcare providers feel satisfaction in their careers. If it is absent, staff turnover will be high and staff performance will be low. However, female healthcare providers in India face many constraints in regard to attaining a similar career growth to that enjoyed by their male counterparts.

- **National Policies and provisions**

While numerous policies and other documents promote the career advancement of women healthcare providers, including the National Health Policy (NHP) 2017, the 11th Five-Year Plan, and guidelines issued by the Ministry of Health and Family Welfare (MoHFW), these have often not been implemented, so that progression from one post to another either happens very late, or not at all. Some details are set out below:

ANMs face career stagnation, due to the much smaller number of available posts at the next level up (Lady Health Visitors (LHVs)), which makes career progression difficult, and due to the lack of LHV training schools in most states. Thus, more than 80% of ANMs retire as ANMs. LHVs, in their turn, face a similar challenge: almost all of them retire as LHVs, without progressing to the Public Health Nurse (PHN) post, since most states do not have PHN posts in primary health centres (PHCs) and community health centres (CHCs). Even more striking, the next post on the career ladder above LHVs, District Public Health Nursing Officer (DPHNO), was created in 1983 but is often vacant or not even created, while the Indian Public Health Standards (IPHS) does not even mention the DPHNO requirements in its guidelines. On the clinical side, in a 2018 study of five states, most staff nurses promoted to sister-in-charge were nearly 50 years old, which means they had spent most of their careers stagnant in the staff nurse position. Finally, turning to community health workers, the major career jump is from ASHA to ANM but, despite being recommended by the High-Level Expert Group for Universal Health Coverage (HLEG) (2011), most states either do not have or do not implement a policy of giving preference to ASHAs in ANM/ General Nursing and Midwifery (GNM) schools, which hinders their advancement.

- **International provisions**

At the international level, India can look to the ILO Nursing Personnel Convention 1977 (No. 149) to guide reforms in this area: the convention requires states to take necessary measures to provide nursing personnel with proper career prospects, including providing leadership positions in nursing care, administration, education, and research and development; and providing facilities like paid and unpaid educational leave, adapting hours of work, and paying study/training costs. In India, none of these are yet recommended at the national level.

Gaps

- Lack of effective implementation and administration of existing career trajectories for nurses.
- Lack of supportive policies for continuing education.
- Lack of emphasis on creation of leadership positions within the nursing cadre.

5. Staffing and working conditions

Female healthcare workers in India face the following problems in regard to their working conditions: an impossible workload (due to too few staff); poor pay; a lack of career development; poor management and supervision; unsafe working conditions; and inadequate infrastructure and resources.

- **National policies and provisions**

The NHP 2017 aims to ensure the availability of community health volunteers as per the IPHS norm in high-priority districts by 2020. However, there is no national standard ratio for nurses, and nurse staffing norms that inform the NHP are far behind international norms.

The HLEG report 2011 recommends putting in place adequate numbers of trained healthcare providers and technical healthcare workers at different levels, giving primacy to the provision of primary healthcare and increasing human resources for health (HRH) density to achieve World Health Organization (WHO) norms.

The Global Strategy on Human Resources for Health Workforce 2030 sets national registries to track health workforce stock, distribution, flows, demand, supply, capacity, and remuneration; and calls for the establishment of an online portal containing national reporting data (the National Health Workforce Account (NHWA)). Although the latter has been set up, there are issues related to the veracity of the data and how often they are updated.

Gaps

- There is a need for a comprehensive HRH policy addressing the contextual HRH deficiencies.
- There is a need for a database to track the health workforce stock, distribution flows, demand, supply, capacity, and remuneration.
- There is a need to create an optimum nurse–patient ratio at the national level to ensure better working conditions.

6. Retention of female healthcare workers in rural areas

The effective deployment and retention of doctors and nurses in rural areas is necessary to ensure universal health coverage but this has long posed in India. The lack of basic amenities and infrastructure (like schooling and proper housing) serve as deterrents to female healthcare providers working in rural areas.

- **National policies and provisions**

IPHS 2012 provides guidelines on accommodation for doctors and nurses at PHCs and CHCs, the creation of a safe and supportive work environment to ensure the increased retention of healthcare professionals in rural areas, and the payment of a home rent allowance in cases where accommodation cannot be provided.

The Working Group on NRHM for the 12th Five-Year Plan (2012–2017) 2011 suggested that group housing be provided for health workers who are deployed in remote areas so that they can live safely with their families. This has occurred in West Bengal, Uttrakhand, and Chattisgarh.

The 11th Five-Year Plan (2007–2012) recommends adequate monetary and non-monetary incentives be provided to ensure medical professionals are available in rural areas on a permanent basis, including accommodation, preferential school admissions for children, and transfer of choice after a stipulated length of stay.

The NHP 2017 proposes that states provide financial and non-financial incentives for the retention of health workers in rural areas, and supports the provision of on-the-job support to healthcare providers working in professional isolation in rural areas using digital tools and other training resources.

Gaps

- The issue of rural retention is usually left to the discretion of states, which has led to *ad hoc*-ism and disparity in the implementation of certain policy provisions.
- Neither the NRHM framework nor the NHP provides for the inclusion of incentives related to the families of healthcare workers posted in rural areas (e.g. schooling of children, employment of the spouse), which serves as a disincentive to women health providers taking on rural postings.
- There is a need for better workforce management, such as transparent posting mechanisms, shorter recruitment procedures, and rotational postings in difficult areas.

7. Leadership and participation in decision-making

Evidence suggests that the presence of women in leadership positions in health results in positive benefits, such as a reduction in neonatal mortality, an increase in health expenditure, better antenatal care, greater levels of immunisation, and the prioritisation of issues related to women. However, there is currently a deficit in regard to women's leadership positions within the Indian health system, due to power imbalances, gender stereotyping, discrimination, and norms which lead to the subordination of women.

- **National policies and provisions**

The Indian Nursing Council Act 1947 provided for the formation of the Indian Nursing Council (INC), a national regulatory body for nurses and nurse education. The High-Power Committee on Nursing (1987) recommended the creation of Nursing Directorates at the state level to operationalise nurse leadership in India. The Draft National Nursing and Midwifery Commission Bill 2020 proposes to replace the INC. SDG 5 on Gender Equality aims to ensure women's full and effective participation in decision-making at all levels. The National Empowerment of Women Policy 2001 and the Draft National Policy for Women 2016 emphasise the need for equal opportunity and an equal role for women in the social, political, and economic spheres.

- **International provisions**

In terms of policies at the international level which India can look to to guide reforms in this area, the WHO policy action paper on closing the leadership gap in health (WHO, 2021) provides concrete guidelines for policy action.

Gaps

- There are no concrete national-level policies to encourage women's leadership in the health system.
- The major leadership positions in the healthcare sector are dominated by men – even within women-dominated cadres like nursing (e.g. TNAI is currently headed by a man).
- Men constitute 79% of the professional health workforce at director and chief executive level, while only 21% of these positions are held by women.
- Most policies on leadership positions are not gender-responsive and do not account for gendered needs.
- There is a disproportionately high representation of medical professionals over nursing professionals in state councils.
- The composition of women in major decision-making bodies usually stands at less than 50%: for example, of the four members of the 7th CPC one was a woman, of the 15 members of the HLEG 2011 six were women, and the Planning Commission for the 11th Five-Year Plan includes one woman out of 16 members.

Key Learnings and recommendations

Key Learning

As illustrated in Fig.1 There is a lack of gender-responsive policies for women healthcare providers in India as most existing national and state provisions are not gender intentional.

- Existing policies that could afford better equity to women healthcare providers suffer from poor implementation.
- Poor representation of women in policymaking roles.
- Gender-responsive provisions are not legally binding and lack any form of accountability.

Thus, a need for decision-making bodies arises to move away from theoretical planning to actual implementation of the existing provisions, to ensure a more robust health system that caters to female healthcare providers.

Figure 1 Overview of Policy Gaps and Recommendations