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KERALA SUPPLEMENT

Health inequities around gender, disability and internal migration: are local governments doing enough?

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SETTING: The Kerala health system in India has more than 25 years of decentralised implementation experience. Decentralization could assist in addressing health disparities such as gender, disability, and migration.

OBJECTIVE: To explore how inequity issues comprising gender, disability and internal migrations were being addressed at present by the decentralised Kerala health system.

DESIGN: Our approach was qualitative, using document review, key informant interviews and in-depth interviews with policy makers, health staff and other stakeholders.

RESULTS: Gender aspects were incorporated into planning and budgeting, with 10% funds earmarked for women. Projects were gender-specific to women, and within conventional social roles of livelihood, welfare or reproductive health. Recently, transgender focused projects were also initiated. Schemes for people with disabilities remained welfare-centric and driven by top-down policies. The local governments performed beneficiary identification and benefit disbursal. Migrant health aspects were focused on infectious diseases surveillance and later living conditions of migrant workers.

CONCLUSION: The importance that health systems place on socioeconomic determinants of health and fundamental human rights is reflected in the health interventions for marginalised communities. In Kerala, there is now a passive application of central rules and a reluctance to utilise local platforms. Changing this is a necessary condition for achieving equal development.

Inequalities in health present a significant obstacle to the achievement of Sustainable Development Goal (SDG) 3, "Good Health and Well-being". Health inequities in India arise from marginalisation due determinants such as caste, socio-economic class, gender, disability or migration status.[1] Kerala State in India is known for decentralised implementation of primary healthcare and has consistently made increased investment in health and social sector, with efforts to empower persons belonging to the marginalised groups.[2] The state envisions progress to SDGs by engaging with local governments for four important sectors: health, agriculture, housing and education.[3] However, some groups in Kerala do not enjoy the same benefits as the rest of the population, including people belonging to the scheduled tribes, tribal communities identified through constitutional provisions as vulnerable and needing affirmative action and protection. Recent studies on tribal health in Kerala highlight the continued vertical nature of the state's engagement with these populations and the challenges thereof.[4,5] Other axes of inequality exist in the state, and are not necessarily determined by numbers of people in a group. Women outnumber men in Kerala, but experience several gendered inequities.[6] Such inequities arise when differences between or within groups are not perceived adequately. This "difference blindness" is created by ideological positions within which policies and programmes exist. For example, population control ideologies that inform reproductive health measures fail to capture high health needs around experiences such as infertility.[7,8] Shakespeare has drawn comparisons between women's issues and disability issues to explain the inadequacies of dominant ideologies.[9] Population migration is an additional injustice resulting from this "difference blindness.".[10]

Soon after the United Nation's Fourth World Conference on Women in Beijing in 1995, the Government of India in 2006 strengthened national governance mechanism for gender equality.[11,12] The 73rd and the 74th Constitutional Amendment Acts of India, 1993, on decentralisation had already made the reservation of one-third of seats in local governments for women mandatory.[13] Decentralisation is expected to decrease inequities through a better understanding of local needs, but evidence is mixed.[14] Exploring whether decentralisation has benefited health of such people may offer insights into challenges and solutions posed by such inequities in the achievement of SDG3 in such settings. Therefore, as part of a broad-based study on decentralisation and health in Kerala, we aimed to describe how three dimensions of health inequity – gender, disability and internal migrants – were being addressed at present.

METHODOLOGY

Axes of inequalities defined

Gender

Gender refers to socially constructed characteristics of women, men, girls, and boys, including norms, behaviours, roles and relationships with each other.[15] Gender inequity pertains to socially constructed aspects of gender that prevent individuals from reaching their full potential of health.[16]

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Disability

The International Classification of Functioning, Disability and Health (ICF) model of disability considers disability as a restriction imposed by situational and social circumstances on persons with medical conditions and related impairments.[17] The resultant health disparity remains unrecognised due to the lack of data, explicit inclusion, access and capacity of workforce.[18]

Internal migrants

Kerala receives large numbers of internal migrant labourers from other parts of India. Poor migrants briefly travel seeking employment in low-skilled, frequently physically demanding jobs.[19] In 2013, there were an estimated 2.5 million internal migrants in Kerala.[20] Internal migrant health in India is affected by historical disadvantages due to the caste system, poverty, child labour and precariousness of occupation.

Study design

The study used a qualitative thematic analysis of document review and interviews. The main study on decentralisation and health had 25 key informant interviews (KIIs). This was the starting point of the analysis for the present manuscript. The study was developed further as follows:

Gender

Five KII transcripts from the main study were included – one senior health department official, one senior public health academician, two retired bureaucrats and a former minister. Documents found relevant to gender sub-theme analysis included two study reports, two planning documents (based on the 5-year planning system that was followed in India), one policy document, and annual financial allocation and expenditure reports of local governments from 2014 to 2020, obtained from the Kerala State Finance Commission.

Disability

We conducted semi-structured interviews with a convenient sample of persons with disability (PwDs), local government-elected representatives and health field workers. Table 1 shows the profile of interview participants (Table 1). We also included one central document that complied many of the official state responses to disability, the state disability census report, 2015.

Internal migrants

We did three additional KIIs on health issues of internal migrants – with two senior health department officials and a senior migrant health activist. We also conducted 10 in-depth interviews in migrant-dense localities in six districts of Kerala – eight participants were frontline field workers of the health department and two were elected local government representatives. We also reviewed one programme report, and two dissertation reports available online and done under the supervision of one of the researchers (RPV).

TABLE 1 Profile of in-depth interview participants for disability sub-theme

	Total	Men	Women
Local government elected members	20	7	13
Health field workers	3	—	3
Persons with disabilities			
Persons with sensory impairment (vision, hearing*)	7	3	4
Persons with cognitive impairment (parents interviewed)	3	1	2
Persons with locomotor impairment	8	4	4

* Person trained in the local sign language conducted the interviews.

Data collection

Documents and participants were selected for their relevance to the study objective. The gender component was explored using excerpts of KIIs from the larger study, which emphasised the gender perspectives in health and local government in Kerala. Key informants were interviewed on developments related to decentralisation and the health sector since the early days of decentralisation in the 1990s. We also reviewed the nature of projects and fund allocation and expenditure by local governments on different micro sectors from 2014 to 2020. The disability sub-theme included semi-structured interviews with open-ended questions using a convenient sample of PwDs to obtain their perspectives on health services provided by their local primary health centre and local government unit. Both the disability and migrant sub-themes included in-depth interviews with health workers and elected representatives of local government, and participants were asked about the interventions available for these groups in their jurisdiction, the processes of planning, beneficiary identification and service delivery.

Analysis

MRN, SSB, DAC, RPV and CSD are biomedically trained public health professionals. MRN has extensive experience in gender and health systems. SSK and KSK are disability rights activists working in the non-governmental sector. We developed an analytical schema based on interpretations of field notes and the impressions and deductive coding was initiated. An interim analysis of the schema was presented to the subject experts, and the schema was revised according to suggestions. After completion of analysis, the findings were presented to a panel of external stakeholders comprising senior experts from academic and administrative fields, and suggestions incorporated into the interpretations. We have attempted to organise the findings from these three subthemes deductively in terms of the nature of the projects expected to facilitate health improvements of marginalised groups, and level of inclusivity based on contemporarily acknowledged needs of such groups.

Ethical aspects

Documented informed consent was obtained from all interviewed participants, with assurance on privacy, confidentiality and non-effect of care. The Independent Ethics Committee of Health Action by People, Thiruvananthapuram, India, cleared the proposal for the study (IEC No EC2/P1/Sep/2020/HAP dated 10 December 2020).

RESULTS

The KIIs and document reviews covered developments from the launch of the Peoples Planning Campaign in 1996 to recent times. The in-depth interviews mostly concerned developments in the last decade, up to the onset of the COVID-19 pandemic. Kerala had excellent conventional health indicators such as maternal or infant mortality at the start of decentralisation; however, the use of a gendered lens for health was still in the early stages. Disability issues, too, were not highlighted in the early years of decentralisation. Internal migrant inflow, being a phenomenon increasingly emerging in the last two decades, gained traction only recently. We therefore could not find objective health information on these axes from the early days of decentralisation.

TABLE 2 Gender-related developments pertinent to health in Kerala

Year	Development level	Summary of development
1995–1996	People's Plan Campaign	Each local government requested to prepare a document on the status of women
1997–2002	9th 5-year plan	Women's Component Plan (WCP) at the local self-government: 10% of WCP outlays for all departments should be earmarked for women-specific projects; livelihood focus and support for self-help groups (*Kudumbashree* Initiative)
2000	State government order to local governments	Clarifications of activities that can be supported using WCP funds
2007–2008	State-level action	Gender Advisory Board set up at state level
2008–2009	State budget	Gender-responsive budgeting: introduced a gender budget statement; it also provides sex-disaggregated data across different sectors
2007–2012	11th 5-year plan	Continued earmarking of 10% WCP outlays for women-specific projects
2009–2010	State Public Works Department (also under decentralised governance) initiative	Gender budgeting by women-friendly amenities and infrastructure facilities in public offices
2010	National Health Mission – Kerala Initiative	Launches *Bhoomika* centres for medical care of victims of gender-based violence; local-level committees under local governments formed to monitor local situations (*Jagratha Samithis)*
2015	State policy	Kerala State transgender policy

Gender in health projects

The documents reviews indicated how Kerala had been relatively progressive in terms of its social and human development indexes for women. Table 2 gives the pertinent developments in Kerala related to gender and health (Table 2). At least 10% of the total budgetary plan outlay has been consistently allocated to women-specific plans.[21] However, many limitations in the understanding of gender remained. The Kerala State Finance Commission report on fund allocation and expenditure by local governments on different micro sectors from 2014 to 2020 showed that interventions remained gender-specific, for women, and were mostly reinstating the conventional gender roles of women in society (Table 3). On a positive note, projects for transgender people were added to the list after the introduction of the Kerala State Transgender policy in 2015. However, projects for transgender welfare, initiated in 2016–2017 with an amount of allocation of around Indian rupees (INR) one million (~USD 13015) was lowered to almost INR0.1 million in 2019–2020. Also, throughout the period, the utilisation of funds was consistently lower than 50% of what was allocated. KIIs conducted as part of the study reflected varied understanding of gender and approaches conventional to dominant norms of femininity. While interventions supporting agriculture and animal rearing by women may improve livelihoods and nutritional security, they mostly ignored the effect on the woman's physical body. Livelihood support programmes did not consider increased risk for women such as musculoskeletal disorders, skin diseases and allergies. Focus on health was limited to maternal functions, and occasionally reproductive health beyond maternal health.

> The bigger concern with respect to health that I feel is that there is not much attention to occupational diseases. Because ...women always work in unorganised sector (and experience the corresponding) health issues; then mental health issues… Another neglected area is elderly women. (KII15)

Promising initiatives included '*Jagrata Samiti*' (vigilance committee) formed at the local government level to address violence against women and children. Crimes against women were emphasised as a major challenge by key informants, who pointed out that this could be effectively addressed by local level action. Specific health issues that may disproportionally affect poor men, such as addictions or accidents, were not mentioned anywhere in the discourse or the documents.

Health of persons with disabilities

The discourse was mainly on financial and non-financial schemes for the welfare of PwDs and institutions specifically serving them, but the level of awareness of such schemes among PwDs, as well as local government representatives, was generally low. Most PwDs reported access issues to the primary health centres and other health institutions even for certification of disability. The main role of local governments was beneficiary identification and

TABLE 3 Micro-sectors related to gender-specific projects prepared by local governments in Kerala, 2014–2020

Sector type	Sector	Sub-sector	Micro sector
Service (local government projects are broadly categorised as production and service)	Sanitation, waste processing	Sanitation and waste processing (individual)	Sanitary napkins for students (she-pad)
			Construction of incinerators in schools
			She-pad storing shelves
		Public programmes	Construction of women-friendly toilets
	Social welfare, social security	Women welfare	Counselling for adolescent girls
			Collaboration with AYUSH for yoga practice
			Self-security training for girls aged 10–20 years
		Social security	Welfare for transgender
			Special programmes for transgender persons
	Nutrition	*Anganwadi* (institutions for the nutrition of pre-school children and women)	For adolescent girls
			For lactating mothers
			For pregnant women

AYUSH = ayurveda, yoga, unani, siddha, homoeopathy (systems other than biomedicine in India).

TABLE 4 Common health issues of internal migrants – findings from three reports

Report name	Migrant health project of local government	Research reports		
		S. Jaya	T. George	
Report details				
Year of report	2017	2012	2015	2015
City/district	Kozhikode	Thiruvananthapuram	Kochi	Kochi
Sample details				
Selection	Migrants (camp attendees)	Migrant clusters (work site-based)	Migrant clusters (residence-based)	Non-migrant clusters from same neighbourhood
Sample size, *n*	703*	283	164	136
Demographic characteristics				
State of origin (West Bengal), %	52.0	38.5	33.5	—
Place of birth (rural)	—	93.6	99.3	13.2
Age group (21–30 years), %	67.7	71.7	52.4	33.1
Education (greater than primary school), %	—	25.1	20.7	92.6
Employment				
Construction, %	45.0	87.6	76.8	13.2
Hotel/shop, %	19.8	12.4	13.4	5.9
Substance use in the past 1 month				
Tobacco, %	—	89.8	67.1	23.5
Health problems				
Reference period	Date of assessment	Past 1 month	Date of assessment	
Fever	6.5	43.8	7.3	0
Cough	5.0	40.3	—	—
Injuries	—	38.9	—	—
OPMD	—	—	39.7	7.4
LBA/joint pain	28.8	—	—	—

OPMD = oral potentially malignant diseases; LBA = low back ache.

pension disbursal. The number of enlisted beneficiaries was the main disability data available with local governments. PwDs reported being referred to inaccessible quarantine centres in the early days of the COVID-19 pandemic.

Health of internal migrant labourers

The main activities considered routine for migrant health included estimation of migrant labourers' settlements and numbers in local self-government institution area, and health squad (team comprising of local government representatives, frontline health workers and law enforcement personnel) visits to setting of the work and living conditions to verify hygiene and sanitation issues at the place of employment or residence. Responses included various migrant-specific measures undertaken when the state was affected by recent natural calamities or the COVID-19 pandemic. Projects were often of a temporary nature and consisted mostly of health camps, screenings for communicable diseases, services for pregnant women, and immunisation for eligible children. Local governments encouraged the convergence of multiple sectors involved with the health and welfare of migrants wherever they were active.

Language barriers, safety issues of women health workers visiting male-dominated migrant settlements and encountering working migrant children were mentioned as the most challenging.

> If we find a child labourer, what we do is send them back to (their domiciled) state. But you have to understand the reality. This child labourer (maybe) the only bread earner in the family... if he goes back, he will have to work…same work he is doing here at a very (low wage) …it may be a caste-based payment that they may get there. (M013)

In Table 4, we share migrant health problems as reported by a local government migrant health project and two epidemiological studies covering the three largest cities in Kerala. Literacy levels were markedly lower than in the non-migrant population. Fever and cough were often reported, and may indicate the need for malaria or TB screening. However, injuries, musculoskeletal problems, substance use and oral precancerous lesions, and skin diseases were more common in the non-migrant population than in migrant workers (Table 4).

DISCUSSION

In this qualitative thematic analysis, we attempted to describe how health inequities arising from "blindness to differences", such as gender, disability and migrant health, is addressed by health and local governments in Kerala.

Gender projects: women-specific, conventional and inadequate

We found that gender-specific interventions for women predominate engagement with gender and health in Kerala. The women component plan (budgetary allocation), *Kudumbasree* (neighbourhood self-help group initiative) and the *Jagratha Samithis* (vigilance against gender based violence) were intended to strengthen the gender-sensitive interventions.[22,23] *Kudumbashree* was also a support system for immunisation campaigns, public health awareness programmes and sanitation activities at the local level.[24] Concerns include the failure to fully utilise the allocated cash for such programmes and the persistence of traditional gendered roles for women in some efforts. The projects on menstrual-related facilities and the development of welfare programmes for transgender individuals might be viewed as a departure from traditional maternity health. Earlier studies on the Women Com-

ponent Plan (WCP) and local governments reported similar findings.[25,26] Ineffective planning and WCP fund utilisation for non-gendered needs were attributed to the absence of gender-disaggregated data and appropriate planning and monitoring tools.[27] Women were increasingly venturing into public spaces and constituted the majority of participants in *grama sabhas* (village fora), but their participation in decision-making roles was comparatively low.[23] Despite the limitations, the decentralised local government initiatives facilitated a more 'gender responsive' approach in Kerala to the COVID-19 pandemic by incorporating elements like mental health and prevention of violence against women during lockdowns.[28]

Disability projects: rights-based discourse not fully translated into actions

Disability is a violation of human rights overlapping with human development concerns.[29,30] PwDs have the same health needs as people without disabilities. They may also have unique complex health needs requiring specialised services (e.g., rehabilitation or assistive equipment) or changes in the service delivery structures (signboards, audio-visual signage and Braille tactile signs to help the visually disabled). We found limited evidence of such interventions. Inaccessible health facilities, as mentioned by our participants in relation to the COVID-19 quarantine facilities, may result in more unmet healthcare needs for PwDs.[31] The lack of such considerations may cause rising inequality, violations of dignity and denial of autonomy of PwDs.[32] The Indian policy environment for PwD advocates for equal opportunities, rights and full participation in society.[33] In 2015, the Kerala government established a policy for PwD that aims for 'access to assets, facilities, and services', 'full and equal participation in public life', and 'barrier-free access' for PwDs in Kerala.[34] Implementation levels of this remain uncertain and accessibility data are not available, as the requisite surveys are not usually conducted. Kerala had also announced a *Kerala Swasraya Scheme 2022*, a new scheme for PwDs.[35] Effectiveness of such schemes may be less than optimal if extra efforts are not made.

Migrants: receiving some attention only recently

Migrant labourers produce substantial economic goods in the state but have consumption patterns limited to basic survival and social needs. The health of these migrant workers has become a priority only recently. Some positive decentralised efforts to mitigate the plight suffered by migrant labourers due to the COVID-19 pandemic have been reported.[36,37] Inequitable conditions at the place of origin may force people to migrate. Additionally, their relationships and the limited availability of resources at their disposal may add to the stress. These experiences may manifest in biological and behavioural mechanisms that influence health outcomes, healthcare, and behaviours like substance abuse. However, health systems were more focused on the protection of the general population from communicable diseases, even when the receiving community benefitted from the availability of migrant labour.[38]

The decentralised governance process in Kerala has created many opportunities for women to come forward to the social and political space. But interventions were mostly gender-specific for women, with limited focus on women's health and welfare beyond maternal health, nutrition and basic livelihood. Disability interventions in the healthcare sector generally follow top-down, welfare-centric approaches. Refusing to accept the responsibility of the state and the non-migrant community for the developmental contributions of the internal migrant population reduces the latter to simple means for the broader community's objectives.

Limitations

Our study is exploratory and did not go into phenomenographic experiences pertaining to how inequity is perpetuated in the current socio-economic and political context in Kerala. We also were not able to clearly portray the situation of gender and disability issues prior to decentralisation, and the changes that have happened since. Also, data collection comprised a mix of physical and telephone interviews due to pandemic-related control measures, and we could not explore the nuances of the projects and processes we encountered. The research team had a predominantly biomedical orientation, but we made conscious efforts to remain critical of our interpretations through discussions and presentations with stakeholders from bureaucratic, as well as non-governmental backgrounds.

CONCLUSION

As part of our research on decentralisation and health in Kerala, we examined the general character of the projects developed by local governments to address health disparities resulting from gender, disability or migration. The involvement of local governments in such issues seems to be part of central or state initiatives, rather than active utilisation of the decentralised platforms for equity, but these issues seem to be gaining momentum at the local level. As an indicator of the importance health systems place on the social determinants of health and fundamental human rights, addressing the health of groups marginalised due to structural and socially constructed vulnerabilities can be viewed as addressing the health of such groups. However, healthcare of vulnerable groups requires addressing many complex issues, and merely having interventions earmarked for them do not suffice. Mapping vulnerabilities at the local level through an equity lens may be the first step to facilitating the planning of appropriate interventions for health improvement of marginalised groups.

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CONTEXTE : Le système de santé du Kérala en Inde possède plus de 25 ans d'expérience de mise en œuvre décentralisée. La décentralisation pourrait aider à lutter contre les disparités en matière de santé, telles que le genre, le handicap et la migration.

OBJECTIF : Examiner comment les questions d'inégalité, notamment le genre, le handicap et les migrations internes, sont actuellement abordées par le système de santé décentralisé du Kérala.

MÉTHODES : Notre approche qualitative s'est appuyée sur une analyse documentaire, des entretiens avec des informateurs clés et des entretiens approfondis avec des décideurs politiques, du personnel de santé et d'autres parties prenantes.

RÉSULTATS : Les aspects liés au genre ont été intégrés dans la planification et les prévisions budgétaires, en réservant 10 % des fonds aux femmes. Les projets s'adressaient uniquement aux femmes et s'inscrivaient dans le cadre des rôles sociaux conventionnels de subsistance, de bien-être ou de santé génésique. Récemment, des projets axés sur les transsexuels ont également été lancés. Les programmes destinés aux personnes porteuses de handicaps restaient axés sur l'aide sociale et dictés par des politiques descendantes. Les gouvernements locaux se chargeaient de l'identification des bénéficiaires et du versement des prestations. Les aspects de la santé des migrants étaient axés sur la surveillance des maladies infectieuses, puis sur les conditions de vie des travailleurs migrants.

CONCLUSION : L'importance accordée par les systèmes de santé aux déterminants socio-économiques de la santé et aux droits fondamentaux de l'homme se reflète dans les interventions sanitaires destinées aux communautés marginalisées. Au Kérala, on constate aujourd'hui une application passive des règles centrales et une réticence à utiliser les plateformes locales. Changer cet état de fait est une condition nécessaire pour parvenir à un développement égalitaire.

Public Health Action (PHA) welcomes the submission of articles on all aspects of operational research, including quality improvements, cost-benefit analysis, ethics, equity, access to services and capacity building, with a focus on relevant areas of public health (e.g. infection control, nutrition, TB, HIV, vaccines, smoking, COVID-19, microbial resistance, outbreaks etc).

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