I. Conceptual Framework

In the context of health, both biologically and socially constructed distinctions of sex and gender are relevant.\textsuperscript{1,2} While the term ‘Sex’ denotes the biological concept and differences in the genetic or physiological characteristics of men and women, ‘Gender’ refers to the social construct representing “culture-bound conventions, roles, and behaviors for, as well as relations between and among, women and men and boys and girls.”\textsuperscript{3} Thus, gender, though based in biology, is shaped by environment and experience, and consequently, a person’s perceived gender role can greatly influence his/her behaviour and thinking.

Until recently, ‘gender in the context of health’ implied a discussion on women’s health. However, it is increasingly being appreciated that an inclusive approach to health attends to the needs and differentials between men, women and other genders, along with the interaction between social...
and biological markers of health. Such an approach also seeks “to avoid the heterosexist assumption that sexuality is tied to male–female anatomical differences.” A gendered perspective would take into account the health needs of all categories of sexual identity; “heterosexual, homosexual, lesbian, gay, bisexual, ‘queer’, transgendered, transsexual, and asexual.”

Thus, gender constructs are linked with sex and determine how men and women seek healthcare, the pattern of burden of disease, how health concerns are communicated to medical practitioners, how diagnostic and treatment decisions are made, and prognosis and responses to treatment (with socio-economic circumstances such as poverty and violence further amplifying gender differentials in recovery-related outcomes). In medical education as well as health research, two forms of gender biases affect health policies and interventions—these include male bias (due to the researcher/observer being a male) and male norm (where results from male participants are generalized to both sexes).

Gender-based marginalization is also associated with class, caste, marital status, and disability. This intersectionality is recognized in a number of international conventions and agreements, and is an important factor in determining and addressing gender equity and health in India. For instance, a low socio-economic status may in turn lead to limited access to resources and less social mobility for women, and this coupled with the deprivation of their decision-making powers makes women more susceptible to poor health.

In India, the plan for Universal Health Coverage (UHC) seeks to ensure equitable access to affordable, appropriate, accountable and good quality healthcare services to all citizens, regardless of caste, gender, age, etc. Reflecting the vision of “health for all” enshrined in the Alma-Ata (1978) and the right to the “highest attainable standard of physical and mental health” in the ICESCR (1966), UHC adopts a rights-based approach, emphasizing the tenets of equity, comprehensiveness of care, non-discrimination, and transparency, amongst others. In order to attain such universality in health coverage, it is essential to achieve Gender Equality (the equal enjoyment by men and women of all ages regardless of sexual orientation or gender identity — of rights, socially valued goods, opportunities, resources and rewards). This may be ensured through Gender Equity (the process of...
being fair to men, women and other genders, being fair to their different needs), **Gender Mainstreaming** (the strategy for making men and women’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated)\(^{10}\) and **Empowerment** (enabling individuals and communities to gain more control over their lives and to shape systems around them, such as the organization and delivery of health services).

Thus, this paper will examine how UHC can be achieved for all genders, keeping in mind gender differentials in health needs, such that the provision of universal health care requires a guarantee of universal access to health care for all genders (including persons of diverse sexualities).

II. Women in India

The Constitution of India prohibits discrimination against any citizen on the grounds of their sex, and empowers the State to adopt measures of affirmative action for vulnerable groups such as women. This is reflected in various domestic legislations\(^{6}\) and international Conventions ratified by India\(^{b}\). In addition, there has been progressive emphasis on the advancement of women in the Five-year plan outlays over the past decades\(^{11}\). Table 1 highlights some of the key schemes for women’s health in India.

However, the political and socio-cultural milieu of the country makes this adoption of a gendered approach to health difficult to implement. Cultural preference for sons is evident in every stratum of the Indian society, even in wealthier ones. Technological advances give son preference further boost through the increased use of sex selection. This, together with policies such as the two-child norm as well as the emphasis on family planning, makes couples more likely to stop having children after bearing sons. Taboos around sex and sexuality affect policies and programmes such as the banning of sex education in schools, family planning initiatives providing contraceptives only to ‘eligible

\(^{6}\) Such as Commission of Sati (Prevention) Act (1987); The Dowry Prohibition Act (1961); National Commission for Women Act (1990); Protection of Women from Domestic Violence Act (2005); Protection of Women against Sexual Harassment Bill (2007).

couples’, and same-sex sexual relationships being considered criminal behaviour as per Section 377 of the Indian Penal Code.\(^1\) The health needs of transgender populations are usually unrecognized and unreported. Norms and attitudes regarding gender roles and relations also shape access to healthcare and health outcomes, with decision-making usually seen as a ‘male’ responsibility.

<table>
<thead>
<tr>
<th>NAME OF SCHEME</th>
<th>YEAR</th>
<th>DEPARTMENT</th>
<th>DETAILS OF WHAT IT COVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Maternity Benefit Scheme (NMBS)</td>
<td>1995</td>
<td>Ministry of Health and Family Welfare</td>
<td>Gives Rs 500 in cash to pregnant BPL women over 19 several weeks before the delivery of each of their first two children. The scheme intends for women to spend the money on nutritious food.</td>
</tr>
<tr>
<td>Kishori Shakti Yojana (KSY)</td>
<td>2000</td>
<td>Ministry of Women and Child Development</td>
<td>Finances a training program for adolescent girls (11-18) that teaches home-based and vocational skills, and awareness of health, hygiene and nutrition.</td>
</tr>
<tr>
<td>Janani Suraksha Yojana (JSY)</td>
<td>2003</td>
<td>National Rural Health Mission, Ministry of Health and Family Welfare</td>
<td>As an expansion and modification of NMBS, JSY gives cash incentives to encourage BPL pregnant women to have institutional births and seek pre- and post-natal care. Pregnant BPL women older than 19 also receive Rs 500 for at-home deliveries for their first two births.</td>
</tr>
<tr>
<td>Indira Gandhi Matritva Sahyog Yojana (IGMSY)</td>
<td>2010</td>
<td>Ministry of Women and Child Development</td>
<td>Provides Rs 4000 to pregnant and lactating women older than 19 over the course of their first two child births. The cash is meant to partly compensate for wage losses and to incentivize breastfeeding and the utilization of health services during and after pregnancy.</td>
</tr>
<tr>
<td>Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (Sabla)</td>
<td>2010</td>
<td>Ministry of Women and Child Development</td>
<td>Revamps KSY, with a new focus on out-of-school adolescent girls, and additionally offers 6 kg of free food grain per beneficiary per month.</td>
</tr>
<tr>
<td>Janani-Shishu Suraksha Karyakram (JSSK)</td>
<td>2011</td>
<td>Ministry of Health and Family Welfare</td>
<td>Provides free institutional services to pregnant women, including deliveries, cesarean sections, treatment for sick newborns up to 30 days, drugs, diagnostics, and transport.</td>
</tr>
</tbody>
</table>


Many of the aforementioned schemes are riddled with conditionalities. In practice, the National Maternity Benefit Scheme (NMBS) has become subsumed under the Janani Suraksha Yojana, even though the functions and provisions of the two are quite different; the NMBS was mainly meant to provide nutritional support, and the JSY to encourage women to have institutional deliveries. However, the restrictions placed on the benefits of these schemes by the Government, especially for age (age limit of 19 years, which is when most women get married in reality) and birth order (discriminates against higher birth order children), has made the rights-based approach conditional, and the earlier emphasis on entitlements has now been lost.

India’s widespread health challenges are apparent at intersection of gender and health. The country accounts for one-fifth of the world’s maternal deaths. India’s multiple disease burdens of infectious disease, injury, noncommunicable diseases, and mental illnesses carry unique challenges for women, and are compounded by deeply entrenched patriarchal norms. Mishra (2006) describes the status of Indian women as “depressed on many socio-economic indices with low literacy rates, poor participation in political processes, concentration in low skilled and low paying economic activities and a culture that values motherhood and care giving roles in women.” The World Economic Forum ranked India as 132nd out of 134 nations in terms of gender equity in health. Table 2 presents some of the key demographic and health-related indicators for men and women in India.

Data from the 2011 Census highlights the gender inequity that continues to persist in India, exemplified by the sex ratio of 914 girls (aged 0-6 years old) for every 1,000 boys of the same age, with great variations between the states. This decreasing figure may be attributable to factors such as the cultural preference for boys reflected in the higher child mortality rate for girls than boys and the increasing use of prenatal screening for sex-determination,. Furthermore, there remains a disturbingly high maternal mortality ratio (MMR) of 212 maternal deaths per 100,000 live births, despite the country’s rapid economic growth rate.

---

Table 2: Key Demographic, Health and Gender Equity Indices for Indian Men and Women

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (years, 2009)</td>
<td>63</td>
<td>66</td>
</tr>
<tr>
<td>Infant Mortality Rate (probability of dying by age 1 per 1000 live births)</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Maternal Mortality Rate (maternal deaths per 100,000 live births)</td>
<td>N/A</td>
<td>212</td>
</tr>
<tr>
<td>Adult Mortality Rate (probability of dying between 15 and 60 years per 1000 population)</td>
<td>250</td>
<td>169</td>
</tr>
<tr>
<td>Nutritional Status of Ever-Married Adults (age 15-49) [Body Mass Index is below normal (%), 2005]</td>
<td>28.1</td>
<td>33</td>
</tr>
<tr>
<td>Literacy rate</td>
<td>82.14</td>
<td>65.4</td>
</tr>
<tr>
<td>Work participation rate (%) in 2001</td>
<td>51.7</td>
<td>25.6</td>
</tr>
<tr>
<td>Men age 25-29 married by age 21 (%)</td>
<td>32.3</td>
<td></td>
</tr>
<tr>
<td>Women age 20-24 married by age 18 (%)</td>
<td>47.4</td>
<td></td>
</tr>
</tbody>
</table>

Gender rankings for India

<table>
<thead>
<tr>
<th></th>
<th>Rank</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Inequality Index</td>
<td>122nd</td>
<td>out of 138</td>
</tr>
<tr>
<td>Gender Equity Index</td>
<td>155th</td>
<td>out of 157</td>
</tr>
<tr>
<td>Women’s Economic opportunity index</td>
<td>84th</td>
<td>out of 113</td>
</tr>
<tr>
<td>Global Gender Index</td>
<td>112th</td>
<td>out of 134</td>
</tr>
</tbody>
</table>

---


r NFHS-3 data (available from [http://www.nfhsindia.org/pdf/India.pdf](http://www.nfhsindia.org/pdf/India.pdf))

s Census of India 2011 data

t The Gender Inequality Index (2011) was calculated by ranking countries taking into account five indicators: Maternal mortality ratio, Adolescent fertility rate, the share of parliamentary seats held by each sex, secondary and higher education attainment levels, women’s participation in the work force. (Available from [http://www.wikigender.org/index.php/wikigender.org:Variables_Gender_Inequality_Index](http://www.wikigender.org/index.php/wikigender.org:Variables_Gender_Inequality_Index))

u The 2009 GEI is based on women’s relative economic activity, education and empowerment. (Available from [http://www.wikigender.org/index.php/wikigender.org:Variables_Gender_Equity_Index](http://www.wikigender.org/index.php/wikigender.org:Variables_Gender_Equity_Index))

v Calculated by scoring 5 categories from the unweighted mean of underlying indicators and scaled from 0-100, where 100=most favourable. Categories are: labour policy and practice, access to finance, education and training, women’s legal and social status, general business environment. (Available from [http://www.wikigender.org/index.php/wikigender.org:Variables_Women%E2%80%99s_Economic_Opportunity_Index](http://www.wikigender.org/index.php/wikigender.org:Variables_Women%E2%80%99s_Economic_Opportunity_Index))

w The GGGI value for 2010 assesses countries on how well they divide resources and opportunities amongst male and female populations, regardless of the overall levels of these resources (Available from [http://www.wikigender.org/index.php/wikigender.org:Variables_Global_Gender_Gap_Index](http://www.wikigender.org/index.php/wikigender.org:Variables_Global_Gender_Gap_Index))
III. Women’s Disease Burden across the Lifespan

The lifecycle approach to gender and health adopted here, advocates the use of strategic interventions during childhood, adolescence, adulthood and old age in various domains of healthcare. The next section will examine the risk factors and disease burdens in these phases, for women in comparison to men. Table 3 presents global data on comparative risk and prevalence rates for disease in men and women.

Table 3: Illustrative Table of Disease Risk for Men, Women (Global prevalence rates)

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart attack</td>
<td>Men have more, but women are more likely to die within a year after a heart attack; women tend to get heart disease seven to 10 years later than men</td>
</tr>
<tr>
<td>Stroke</td>
<td>Women have fewer strokes, but are more likely to die from them than men; women are generally older than men when they have a stroke</td>
</tr>
<tr>
<td>Depression</td>
<td>Twice as common in women</td>
</tr>
<tr>
<td>Migraine</td>
<td>Three times more common in women</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>More common in men</td>
</tr>
<tr>
<td>Nearsightedness (myopia)</td>
<td>More common in women through age 60</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>More common in women</td>
</tr>
<tr>
<td>Cancer</td>
<td>Cancer of the lungs, kidneys, bladder, and pancreas are more common in men; thyroid cancer is more common in women</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>More common in women</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>Two to three times more common in women</td>
</tr>
<tr>
<td>Gout</td>
<td>More common in men</td>
</tr>
<tr>
<td>Lupus</td>
<td>Nine times more common in women</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>Nine times more common in women</td>
</tr>
</tbody>
</table>

a) Childhood

Data from NFHS-3 revealed that in 2005-06, while neonatal mortality rates were higher in boys, post-neonatal mortality rates were higher for girls, demonstrating that gender discrimination leading to inadequate care nullified the girl child’s biological advantage over boys during the first few years of life. Moreover, preferential treatment towards the male child coupled with the limited resources in poorer families and the lack of family planning results in tragic consequences such as female infanticide in many parts of the country, especially the rural areas. Research has also shown a care-seeking bias against girls, with only one female neonate admitted to a health facility compared to every two male neonates. Accordingly, NFHS-3 showed that, in India as a whole, although mortality rates were higher in boys in the first month of life, child mortality rates were 61% greater for girls after the first month up till age four. Child abuse and maltreatment represent additional risk factors for ill-health in young girls and boys, with over 50% of the sampled children in a 2007 Indian study reporting facing some form of physical, sexual or emotional abuse.

As depicted in Table 2, there are differences in the nutritional status of boys and girls, which may be due to reasons such as gender biases in breastfeeding patterns of mothers and inadequate dietary intake in Indian girls compared to boys with substantially lower average calorie intake than the Recommended Dietary Allowance in girls. Moreover, the additional intersectional effect of gender, education and socioeconomic status is also an important factor to consider, with findings indicating that increases in infants’ levels of nutrition are directly attributable to improvements in women’s education and in their socio-economic status compared to men.

b) Adolescence

Complications during pregnancy are the leading cause of death among 15-19 year old girls in India, and median maternal age at first delivery is 19.9 years, with roughly 30% of girls giving birth before the age of 20. The Indian Council for Medical Research found that maternal mortality among adolescents at ten study sites was 645 per 100 000 livebirths, in contrast to 342 per 100 000 livebirths in women aged 20–34 years. Early marriage and child-bearing can pose several additional health risks, including pregnancy-related complications, unsafe deliveries, improper prenatal and postnatal care and miscarriage. Child marriage is a common phenomenon in India, with 40% of the world’s child marriages occurring in the country, and 47% of India’s 20-24 aged women reporting
that they were married before the legal age of 18 years.\textsuperscript{26} This poses substantial risks for young women being caught in violent marriages as well as acquiring infections from their husbands.\textsuperscript{27} Even outside of marital relationships, adolescent girls face multiple health risks: a 2007 study of the health of adolescent girls in backward districts of India found that almost two-thirds reported some form of sexual abuse in their lives to date.\textsuperscript{28} Findings point towards a crucial need for education in reproductive and sexual health – including issues of reproductive and contraceptive choice in schools and comparable settings accessible to youth.\textsuperscript{29}

Moreover, mental health problems associated with puberty, identity crises, and role transitions constitute a large proportion of the burden for adolescent girls.\textsuperscript{30} Occupational hazards due to physical labour and domestic work (especially in agricultural areas) can be particularly damaging for the underdeveloped and undernourished adolescent girls in rural areas. This period also brings additional health risks in girls related to diet and nutrition (due to changes in perceptions of body image and eating behaviors), and the use and abuse of substances such as tobacco and alcohol (especially in the urban population). Gender differences are apparent in tobacco use, with 33.2% of Indian boys under the age of 15 years smoking tobacco, compared to 3.8% girls under the age of 15 years in 2006.\textsuperscript{m}

c) Adulthood

The Global Burden of Disease Report (2004) states that worldwide, over 104,000 adult women aged 20–59 years die from unintentional fire-related injuries every year and 80% of these fire-related deaths occur in South-East Asia.\textsuperscript{29} Hemorrhage, hypertensive disorders, sepsis, and complications of abortion are the leading causes of maternal death, and although there has been a decreasing trend in maternal mortality over the past few decades. Studies indicate that anemia (iron deficiency) affects 50-90% of pregnant women in India, and significantly increases the risk for maternal deaths due to hemorrhage.\textsuperscript{30} There is a large unmet need for contraception amongst Indian women due to difficulties in access, lack of awareness about non-terminal methods, and limited communication between couples.\textsuperscript{31} Significant health complications also arise due to unwanted pregnancies and subsequent unsafe abortions. Moreover, the country has limited access to safe abortion facilities, especially in rural areas where more than 70% of Indian women live. Other barriers to proper care include the lack of awareness of the provisions of the Medical Termination of Pregnancy (MTP) Act, societal stigma, poor quality of care and the lack of trained workers in abortion facilities.
d) Old Age

India is unique in that the life expectancy of men and women are roughly similar despite the biological advantage of longevity that women have over men. In India, the life expectancy at birth is 66 years for women and 63 years for men, however this longevity brings with it a considerable burden of disease for elderly women. Women in this age group face double discrimination due to sexism and ageism. Additionally, women over 60 years tend to have greater disability and more comorbidities than men of the same age-group, which may be due to biological factors such as lower muscle strength and bone density in women compared to men, as well as social factors such as restricted access to nutritional food and healthcare facilities across the lifespan. This period may be particularly difficult for women during menopause, during which the hormonal changes are associated with an increased risk for cardiovascular disease and depression, heart disease causes more deaths in older women than men. The symptoms presented by women with heart disease tend to be different from those of men. Moreover, women are less likely to seek or receive appropriate and timely care for the condition, and are often underrepresented in cardiovascular risk research. Another cause of disability in this age group is the loss of vision due to cataracts and uncorrected refractive errors; elderly women in India receive and use significantly less cataract surgical services than elderly men. Another serious illness in this age group, for both men and women, is cancer. Breast, stomach, liver and and cervical cancers are the most common among women in developing countries, whereas lung, colon and prostate cancers being the deadliest killers among men. Osteoporosis and arthritis cause severe disability in this age group, especially for women, with the incidence of osteoarthritis rising 20-fold in women as compared to 10-fold in men between the ages of 60 and 90 years. A considerable health burden in this age group is also experienced due to neuropsychiatric conditions, especially dementia and depression.

e) The Burden of Mental Illness and Domestic Violence

Women are afflicted with a considerable hidden burden of disease which is often not accounted for in morbidity figures. Evidence indicates that there is a trend towards the growing burden of non-communicable diseases, in India and the world. It has also been noted that neuropsychiatric conditions, especially the recognition and reporting of mental disorders continues to be low and practically non-existent in most parts of the country. Between 30-50% of women in developing countries suffer from depression during pregnancy and childhood, which has severe health implications for the mother and the child. In a review of Indian studies, Davar (1999) found that
women are twice as likely to suffer from common mental disorders as men.\textsuperscript{40} The social roots of women’s mental health problems (including sexual violence, poverty, and dowry harassment) are often ignored due to gender insensitivity and the medicalization of their psychosocial symptoms. Violence against women remains high in India and a study by INCLEN reported that 40.3\% of the women sampled reported at least one instance of physically abusive behaviour in their lifetime.\textsuperscript{41} In fact, the figures for gender-based violence are often unrepresentative of the magnitude of the problem, due to the sensitive nature of the topic and the internalization of gender roles. A report by WHO-SEARO discusses how suicide, an extreme manifestation of these hidden burdens, is now a leading cause of death among young women in India and China.\textsuperscript{42} Moreover, unsuccessful suicide attempts may leave deep physical and emotional scars that are often kept under covers due to societal norms.

f) Health status of diverse sexualities and other vulnerable populations

An overarching and problematic phenomenon related to gender and the health of various Indian populations is the larger assumption that reproductive health (only) applies only to women and that sexual health (only) applies to populations of diverse sexualities (often inaccurately misrepresenting or conflating people who are queer identified, bisexual, transgender, or involved in same-sex relationships as merely “high risk”). This “invisibilises” the sexual health concerns affecting women and men, varying reproductive issues faced by different sexualities, and moreover, that all groups have other health concerns and needs as well. The first key point to note, therefore, is that all genders have concerns related to sexual and reproductive health, as well as other health issues. The health status of vulnerable and minority populations is a key concern in a Universal Health Coverage framework.

For Indians of non-heteronormative sexuality, perhaps the largest barrier to health is the criminalisation of same sex relationships in India’s Indian Penal Code 377 – which expressly marginalizes them from accessing health services, prominently in the HIV/AIDS arena.\textsuperscript{43} A recent exception has been the 2009 ruling of the Delhi High Court that criminalization is unconstitutional on grounds of dignity, equality, and freedom discrimination on grounds of sexual orientation.\textsuperscript{44} Notwithstanding this encouraging development, non-normative gender/sexual identities face stigma and discrimination in family, workplace, and other settings, police harassment, in some cases the threat of conversion therapy from mental health professionals, and vulnerability to suicide, depression, and a host of health problems arising from neglect in the larger public health
system. Transgender populations in India face similar marginalisation, given the lack of guidelines in India around sexual reassignment, clear protocols of access to services, and mechanisms of redressal in case of discrimination. In healthcare settings in particular, transgendered Indians have had to face discrimination on the basis of transgender status, sex work status, HIV status, or a combination of the aforementioned.

Sex workers of all genders face major challenges in protecting their health and accessing health services. Even renowned examples of community mobilization among sex workers such as Sonagachi have involved complex and contradictory negotiations within highly patriarchal and hierarchical systems. As a result, the disease burdens faced by these groups are considerable: for example, sex workers and their “bridge” partners (truck drivers, migrant labourers, men who have sex with men) have between 6 to 8 times the HIV prevalence of the general population. Marginalisation from the health system, as suggested above, occurs in intersections; i.e. health status overlaps with social status, employment, and gender. This is the case for other vulnerable populations as well, such as those from SC/ST populations, and religious minorities. In Kerala, more 88% SC/ST women and 73% more OBC women were likely to report poor health as compared to forward castes. Thus, these have unique health needs which should be taken into account, especially due to the multiple burden caused due to intersectional interactions of vulnerable sexual status, poverty, and class.
IV. Recommendations for a Gender Perspective on Universal Health Coverage

The previous section highlighted the dire need for gender-based healthcare services. However, there are several barriers to the provision of and access to these services, which should be factored in while framing recommendations for UHC. These include: a) Political and legal barriers such as the misplaced emphasis on population control policies while fertility rates decline, the lack of political will for sexuality education and gender-sensitization; b) economic barriers such as user fees for maternal health services, the burden of healthcare loans repayment for poorer families, and the dearth of affordable public primary care services, which makes inevitable the use of private tertiary services; c) social barriers such as stigma attached to certain illnesses such as HIV/AIDS (especially for men who have sex with men who face greater social and epidemiological risks) and depression (higher among women and access to services lower); d) health system barriers such as the shortage of human resources for health, lack of gender sensitization among health care providers and lack of linkage and integration in current provisioning, which lacks primary care and rural coverage.

While the country’s health system has a considerable distance to go in order to become truly gender-sensitive, important steps need to be taken in the following core areas in the move towards Universal Health Coverage:

- Acknowledging gender diversity through the life-cycle during the conceptualisation and delivery of services
- improving access for women and other vulnerable genders;
- recognizing the key role that women play as formal and informal providers of health services and empowering them for that role;
- strengthening data, analysis, and monitoring and evaluation systems in order to make them more gender sensitive; and
- supporting and promoting the rights of girls and women to health in families and communities as well as through programmes and policies.

The recommendations that follow address these adopt a gendered approach to health service provision, financing, service delivery, access to medicines, human resources for health, and governance and accountability.
a) Package of Essential Services

**Recommendation 1**: Utilizing the life-cycle approach that allocates greater financial and human resources based on the varying burden of disease across health areas, the basic package of services should be conceptualized keeping in mind gender differences between men and women.

Moving towards Universal Health Coverage involves progress along three dimensions: the *depth* of coverage (expanding the range of essential services); the *breadth* of coverage (increasing the extent of population coverage); and the *height* of coverage (removing financial barriers in accessing health care, in terms of decreasing the out of pocket expenditure on health and providing financial protection from catastrophic costs through pooling and prepayment mechanisms).

Section 2 presents the various morbidities that women face through their life cycle. However, contextual differences in the living and working conditions of women and men necessitate periodic regional assessments of their health problems in different parts of the country and in different occupations and income groups. This section looks at what services need to be provided and how they need to be provided to ensure gender equity.

The basic package of services that should be covered for girls and women should include a) nutrition packages to address anaemia and malnutrition beginning from pre-adolescence; b) Reproductive Health including Maternal Health (Body Literacy, Reproductive Tract Infections (RTIs), Sexually Transmitted Infections (STIs), menstrual disorders, uterine prolapse, contraceptive care, ante natal, intranatal, post natal care, and safe abortions); c) screening for domestic violence and requisite care; d) screening and care for occupational health problems, e.g. agricultural women labourers exposed to pesticides, women workers with back aches; d) infectious diseases and their interaction with the biological pregnancy related conditions – e.g. Malaria or Tuberculosis (TB) during pregnancy; e) mental health services including counselling for common stress-related conditions.

For men and boys, services should cover cancer of the lungs, kidneys, bladder, and pancreas that are more common in men; tobacco cessation and drug de-addiction services; safe sexual practice; chronic disease include stroke and heart disease; as well as sexuality education and counselling, to bring about greater sensitization towards women’s health needs.
Under Universal Health Coverage, the definition of ‘maternal health’ needs to be expanded beyond childbirth in hospitals to include nutrition, wage loss entitlements, breastfeeding support in the workplace, and services for maternal morbidities. The approach needs to be one of maternity entitlements, extending to child care and crèches. Under UHC women should be assured of specific health entitlements like maternity leave, abortion leave, sterilisation leave, toilets and crèches. Sexuality Education for boys and men would begin from body literacy and expand to include an understanding of how masculinities shapes male sexuality and resultant risk behaviours such as substance abuse and unsafe sexual practices. Another point to note is that hospital wards, beds and toilets are always in binary divisions such as male and female. There are no facilities for transgender persons. Their special health needs also need to be factored in for the basic service package. Case Study One in Annexure 1 gives an illustrative example of the transgender community in Tamil Nadu, whose rights have been recognized by the State government.

A gender bias is seen in the way reproductive health and sexual health are considered as exclusive health needs of women and men respectively. For instance, reproductive health services are targeted towards heterosexual women who are, or will be, mothers and therefore the Reproductive Health Programme for women. Sexual health services, especially in relation to HIV/AIDS, are considered needs of men, and hence the National AIDS Control Programme. These kinds of gender biases need to be addressed during the sensitization and training of health care providers as well as while designing Essential Service Packages for men and women, including for persons of diverse sexualities.

Supportive programs also need to be conceptualized for women who are victims of gender-based violence. For example, Malaysia opened its first One-Stop Crisis Centers (OSCC) in 1994 in Kuala Lumpur as a pilot program to provide female victims of domestic and sexual violence with multi-sectoral support. The OSCC model offers medical services, psychological counseling, shelter, and legal support to female victims of violence in a single hospital to better centralize care. Various NGOs are currently conducting training initiatives to gender-sensitize health care personnel by educating them about the causes of violence against women and the legal perspective on violence and rape. Case study Two in Annexure 1 describes the ‘Dilasa’ domestic violence crisis centre in Mumbai.

Improving access to services goes beyond removing the financial barriers that prevent women and weaker sections of society from accessing services. It addresses health system barriers that fail to
acknowledge the gender and social differences in how diseases manifest differently in men and women or their differences in health seeking behaviours. Sexual and reproductive health services for underserved groups like older women, adolescents, men and persons of diverse sexualities also need to be provided. Sex and gender differences - for example, higher depression amongst women and higher substance abuse amongst men, or the fact that while prevalence of malaria amongst men is higher, its consequences for pregnant women can be fatal – need to be factored into the design and content of services for women and men. Men need a range of services like sexuality counselling, vasectomy, urology, and health education to counter substance abuse and so on. Staff who have been oriented to the differences in women’s and men’s health needs and are sensitive to these will help increase utilisation of these services.

The breadth of coverage needs to be expanded to recognize and address the health needs of vulnerable groups. Provision of counselling at the level of families as well as the individual would be needed. Sex workers also have sexual and reproductive health needs that should be provided without any judgement or discrimination.

b) Service Delivery

**Recommendation 2:** The delivery of the basic package of preventive, promotive and curative services should be gender-sensitive and gender-responsive, such that it is provided closer to women and girls at the community level; the timing of delivery is responsive to women’s multiple work burdens and lack of mobility; and there should be continuity of care across the various levels and facilities of care.

The basic package of services should be provided closer to the people at the primary level, implying increased and better equipped infrastructure; more healthcare providers at the primary level; as well as community based care programmes such as day care centres, palliative care, domiciliary care, and ambulatory care that can support home based health care provision. The prevalent pattern in most countries is that minimal curative services are provided in primary health facilities. This leads to delayed treatment seeking, or treatment seeking from private providers resulting in high out-of-pocket (OOP) expenditure, irrational care at the hands of informal providers, as well as overcrowding at the secondary and tertiary levels for basic curative services. Unlike fragmented care provided through multiple facilities, integration of services will also increase utilisation. Providing integrated child care, family planning service and antenatal care would enable women to utilise their time better. Integration of services through a Reproductive and Sexual Health Clinic will also reduce
the stigma that women fear when they seek abortion or care for RTIs/STIs and infertility. Integration of vertical programmes, like Nutrition with MCH, TB and Malaria with Maternal Health, chronic diseases – diabetes, hypertension - with sexual and reproductive health will also improve women’s access to health care.

Transportation costs and heavy workload may deter men and women from travelling far to access services. Lack of information about available services and their entitlements may be another reason for lower treatment seeking amongst women. Factors influencing men’s treatment seeking may be different. The fact that condoms are available in maternal and child health (MCH) clinics may prevent men from seeking sexual and reproductive health services. Services for men are best availed of when provided at workplaces or social environments such as clubs, sports venues, local cafes and tea shops. Services that are provided when men and women are not at work – off days or off-peak work times - will also help improve access and increase utilisation. Thus, the location and timing of health service delivery at all levels should be adjusted so as to be responsive to women’s multiple work and time burdens, differential health-seeking patterns, lack of mobility, and transport costs.

**Recommendation 3:** Patient-provider interaction related aspects of service delivery need to be made gender-sensitive, such that healthcare providers are trained to be responsive to the specific needs and concerns of girls and women, as well as poor and marginalized patients.

Patient provider interaction is another important aspect of gender responsive health care delivery. A major deterrent for women and other excluded groups to seek treatment is the behaviour of health care providers. Perceived power relations between ‘weaker’ women clients and the more ‘powerful’ health care providers leads to women being non-assertive, and inarticulate in their interactions with health care providers. Health care providers need to be sensitised to class, caste and gender issues through their pre and in service training. Professional ethics and responsible care-giving also need to be stressed upon. Patient Provider interaction needs to be an empowering process, where patients are provided information about their condition in ways that they can understand, and are helped to make their own decisions about treatment options. Providers should encourage women to ask questions and to pay attention to their verbal and non verbal communication. Safety for patients, especially women patients has to be ensured through privacy and confidentiality. Providers should monitor for signs of gender based violence. The sex of the provider is another important aspect that determines whether men and women will access health care or not. In many cultures women will not approach male health care providers and vice versa.\(^{54, 55}\) It is important to have a gender balance
in health providers, including the Community Health Workers, Multi purpose Workers, as well as Doctors.

c) Provision of Essential Medicines

**Recommendation 4:** All product literature related to medicines should specify adverse drug reactions on pregnancy and lactation and their general impact on reproductive health of women. At the same time the market should not be allowed to dictate what is available; essential medicines for women should be available irrespective of their low profit margins.

Drugs affect the foetus in many known and unknown ways, and sometimes the effects of drugs are latent and are visible only after some years, and are manifest among women, their children or grandchildren. Women also metabolise drugs differently than men. There is evidence to show that drug safety data are analysed by gender only in 54 percent of the cases and efficacy analysed by gender only in 43 percent of the cases.\(^5\)\(^6\) (However a recent review of 59 studies comprising data from more than 250,000 patients suggests that for the majority of drugs, no substantial differences in efficacy and safety were found between men and women.\(^5\)\(^7\)

Women are targets of provider-centric population control and disease control policies like injectable contraceptives, oral contraceptive pills, hormonal drugs, fertility regulators, and IUDs. Very little is known about the post-reproductive effects of drugs (such as menopause, menstrual regulators, and hormone replacement therapy) on the metabolism of women.

Women in India, especially poor women, are the target of clinical trials by Contract Research Organisations – like the recent incidents of HPV vaccine ‘demonstration’ trials on tribal girls.\(^5\)\(^8\) Many of these trials need better regulation, better ethical oversight of trial rollout and management of adverse events, and better compensation policies in case of loss of life. Furthermore, participation in trials should be based on informed consent and there should be strict adherence to guidelines for ethical approval.

Even though a large number of women in India are anemic, it is difficult to get iron-folic acid tablets in retail shops in India as they are very low cost and therefore cannot give enough returns to manufacturers. Likewise other drugs, like Co-trimoxazole for bacterial infections and tamoxifen for post-breast cancer cases, are overpriced and should be made accessible and affordable. Sanitary
pads (not strictly a drug but would qualify as a drug by definition under India’s Drugs and Cosmetics Act), an essential for personal hygiene in women, need to be affordable. Case Study Three in Annexure 1 provides an illustrative example of a unique model of gender-sensitive cost-effective solutions to increasing menstrual hygiene for rural women.

Thus policy measures should:

- Ensure that the National List of Essential Medicines contains essential medicines and devices for sexual and reproductive health recommended by the UNFPA and WHO, and they are made accessible and affordable.
- Ensure that adequate gender analysis is included, and involve vulnerable genders in all pharmaceutical-policymaking.
- Promote gendered aspects of medicine access, use and affordability, including:
  - Focusing on the need to develop drugs for women-specific problems across the life-cycle.
  - Ensuring vaccines related to women-specific problems are reasonably priced and are introduced only after evidence-based cost-risk-benefit analysis.
  - Ensuring women have access to drug related information (such as effects of dosage on lactation, pregnancy and on reproductive systems).
d) Human Resources for Health and Management Reform

Recommendation 5: Recognise and strengthen the role of women in health care provision, within both the formal health system and in the home by improving the working conditions for women; expanding career trajectories for women; and increasing the number of women in higher positions in health management, especially nursing professionals.

Working conditions of a large number of women involved in the health sector as carers needs addressal, especially concerns about safety, transportation, housing, hygiene and sanitation; as well as maternity benefits, their need for within-district appointments, and regulation against sexual harassment. The personnel policies in the health sector need to be gender sensitive, respecting health care providers’ role as reproductive beings and encouraging male health care providers’ participation in home making and family care. Transfer and postings policies should consider providers’ life stages, i.e. post those with young children or responsibility of aging parents closer to education facilities or their homes. Promotion policies should not disadvantage women who need to take breaks for child bearing and child rearing. Working conditions should include adequate supplies and infrastructure (see Case Study Five on professional midwives in Sri Lanka), safe residence, provision of separate functional toilets in health facilities with waste disposal, extra mentoring and professional support that they might require. Recognition of women as workers also implies that policies that prevent sexism and sexual harassment as well as grievance redress mechanisms, if these do occur, are in place.

The health sector is one that absorbs highest number of women, largely because of their socially prescribed role as carers. A large proportion of the women in the public health system in India, are employed as frontline workers – Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs), Anganwadi Worker (AWWs), Nurses. Comparatively, the proportion of women in health policymaking and in health management positions is very low. Even when women are in management positions (for example the Directors of Nursing and Nursing Administrators), within the health sector, the hierarchy between Doctors and Nurses is such that women have less power and leverage than men. Career advancement avenues and possibilities of further training for all cadres should be formulated through time-bound programmes, with appropriate consideration of family leave allowance and career re-entry prospects, supportive supervision, and equal opportunities for further training and studies. For example, ASHAs with five years experience would be given preference in ANM training schools, ANMs who are working well
should be able to undergo training to become Supervisors (or LHV) or Public Health Nurses. Nurses should be allowed to specialise – as Nurse Practitioners, or Midwives or as teaching faculty.

Unpaid and invisible health work is the care provided to the ailing, disabled and the elderly within the household. This includes preventive and promotive services, first aid in the community, accompanying community members to health centres and hospitals, and so on. This kind of care is not formally financially compensated and is largely provided by women as part of their socially prescribed roles as carers. The burden of unpaid caring within the households is increasing because of various reasons – better life expectancy and aging populations; increasing chronic diseases, mental illnesses, accidents and injuries because of life style changes; health sector reforms which make hospitalisation expensive and patients are discharged early; are some of the reasons. The burden of unpaid health work is likely to be highest in low income households because they cannot afford paid home care and may also have higher incidence of illness and long-term disability. Unpaid, home-based health care needs to be accounted for in the National Health Accounts so as to arrive at a realistic estimate of the contribution of households and women to the health sector.

e) Governance and Accountability

**Recommendation 6:** Build up the capacity of the health system to recognize, measure, monitor and address gender concerns through improvements in data gathering, analysis, monitoring and evaluation, and enhanced accountability measures.

Good governance in health implies a health system that is responsive to the needs of all its citizens, and is structured in such a way as to achieve health sector objectives such as accessibility, affordability, quality and equity. Accountability is a related concept and involves discussions of problems in the public sector, private sector as well as in the non-profit sector. The gender perspective in governance emphasizes the importance of judging projects by gender equality outcomes and on whether women’s strategic needs are addressed.

Why is gender important in health governance? As discussed earlier, men and women may have different health needs depending on their position in society, the roles they are engaged in as well as because of their biological make-up. It then follows that men and women may be impacted differently by policies and structures that are put in place by health governance institutions. Incorporating gender issues in health will ensure that decisions taken by governance institutions take into account the different needs of men and women. Failure to do so may even sometimes worsen the position of women in terms of access to basic services and other resources.
In the context of Universal Health Coverage, health governance and accountability mechanisms would encompass:

- ensuring that all health data (whether collected through the MOHFW, the centralized statistics collection systems such as the National Sample Survey, the states, or others such as the National Family Health Survey) are disaggregated by sex and age; and are reported and analysed on these bases;
- supporting the major resource centres for health analysis such as the NHSRC, SHSRCs, NIHFW, SIHFWs and others to build their capacity for gender analysis (including gender budgeting) in a time-bound manner (see Case Study Four in Annexure 1) in order to make recommendations and support convergent action towards ensuring the health of women, girls, and gender minorities;
- requiring monitoring and evaluation systems (including for example the annual Common Review Missions under the NRHM) to address performance on the basis of gender through clearly developed criteria and indicators; and
- mandating representation of women professionals, especially nurses, in high level health management.

Such changes will require systemic assessment of institutional capacity in gender planning and mainstreaming, which will require the creation of roles and spaces for women and minority genders in shaping the agenda. As suggested above, women should be represented in high level health management as well as other decision-making bodies including Rogi Kalyan Samities, Village Health and Sanitation Committees, Block and District level committees. There is, moreover, a key role in regulation of the private sector using a gender lens that ensures that nobody is not exploited in, for example, international reproductive health tourism - such as surrogate pregnancies and Assisted Reproductive Technologies, or clinical trials for various drugs, vaccines, medical products, and stigmatising interventions. Regulatory frameworks ensuring safety, transparency, accountability and compensation and redress are essential.
REFERENCES

12. Citation pending for one fifth maternal deaths


CASE STUDY ONE: Transgender rights in Tamil Nadu 

Over a third of India’s estimated 500,000 transgenders are Tamil Nadu’s aravanis, or those with half a voice. Additionally vulnerable in the face of the HIV epidemic, many self help and community based organisations of transgenders began emerging in Tamil Nadu in the 1980s, 1990s, and 2000s. The mandate of many of these organisations was advocacy against stigma, ensuring access to health services and opportunities for income generation.

In the late 2000s, the efforts of these groups culminated in the Tamil Nadu government issuing a number of policies to support and recognize aravanis. This included issuing ration cards, constituting a Transgender Welfare Board, conducting a census of aravanis, and allowing them a share of the 30% of seats reserved for women in government-owned and government-aided arts and science colleges. Moreover, Tamil Nadu is the only state in India where sexual reassignment surgery may be undertaken in the public sector. January 24th, Aravani day, is marked by a number of events to celebrate transgender identity in Tamil Nadu, offer services, and advocate for improvements in entitlements and access to health for this key population.

CASE STUDY TWO: India’s First Domestic Violence Crisis Centre: Dilaasa

In Mumbai, a partnership between a health policy NGO and a municipal public health department led to the first hospital-based domestic violence crisis center in the country. Known as Dilaasa, the center is based near the casualty ward at the K.B. Bhabha Municipal General Hospital in Bandra, Mumbai. Dilaasa, designed as a one-stop center, is staffed by a social worker, a part-time doctor, and a part-time clinical psychologist. A lawyer also visits the center once a week.

The project began with a needs assessment conducted by the Dilaasa NGO partnership, which examined the operational structure of the hospital’s response to victims as well as the knowledge and perception of staff about domestic violence. A checklist of signs of domestic violence was developed and distributed throughout the hospital. After the needs assessment, the project began a train-the-trainer program for hospital staff and a new program to provide a 24-hour emergency shelter for women who cannot be admitted to other local shelters.

The Dilaasa model allows for integration: information about the center is available throughout the hospital on posters and pamphlets. All doctors have access to screening checklists to identify victims of domestic violence. Women referred to the center meet a counselor for assistance with shelter and safety planning. Information about legal rights is available and legal recourse may be sought with Dilaasa’s lawyer. Dilaasa’s referrals have increased steadily, from 111 in the first year of operation to 340 in the fourth year.
CASE STUDY THREE: Jayashree enterprises-- Income generation for menstrual hygiene

Menstrual hygiene relates to several Millennium Development Goals (MDGs): universal education (MDG 2) because it stands between girls and completion of education upon reaching menarche; gender equality (MDG 3) since women are disproportionately affected by a number of unique health-related concerns from menarche to menopause; maternal health (MDG 5) due to the reciprocal link between menstrual hygiene, parturition and environmental sustainability; (MDG 7) since eco-friendly sanitary disposal is a key concern for communities seeking the introduction of feminine hygiene products at scale; and finally global partnerships (MDG 8) since recent of innovations to improve menstrual hygiene involve collaboration between local and national governments, innovators, pharmaceutical and other multinational corporations and communities.

A unique example of this kind of convergence is Jayshree enterprises, an operation begun by A. Muruganantham in 2006, which supplies women’s self help groups an wood-based sanitary napkin-producing machine. So far, over 250 machines are in operation across 18 states and several hundred women are franchisees, with some earning from over 5,000 to over 10,000 Rupees a month. Pilot data suggests that the product is more effective than cotton based pads and can last a whole day, offering relief in particular to rural Indian women. This initiative has won accolades from the Indian President and is now a model of gender-sensitive cost-effective community-run hygiene practices.

CASE STUDY FOUR: Gender Responsive Budgeting: Sakhi’s contributions in Kerala

Gender responsive budgeting is a form of resource allocation that applies a gender analysis to the examination of overall government budgets to assess how the different needs of men and boys, women and girls and other genders are addressed. In Kerala, a gender advocacy organisation called Sakhi facilitated a gender responsive budgeting exercise in 2008-2009 under the auspices of the State Planning Board for the Ministry of Women and Child Development, Government of India. Analysis revealed that with a few exceptions, targeted programmes for women were under departments traditionally looking after women’s affairs. Most programmes were concentrated in Social welfare including welfare of SC/ST/OBC, Family Welfare and Rural Development. The largest women specific programme, Kudumbashree is included under community development. The analysis also found a lack of gender disaggregated data at the secondary level and while formulating projects / schemes by Departments, which hampers the estimation of anticipated flow of resources to women. In the 11th state plan, flagship programmes on domestic violence and skills training for women were introduce. The cumulative outlay earmarked for women amounted to only 5.5 % of the total State budget outlay in 2008-09, which increased to 8.5 % in 2010-11.

The process of incorporating gender responsive budgeting in Kerala is ongoing, supported and endorsed by the political leadership. It serves as an accountability measure, a form of increasing participation of women in planning processes, and the introduction of novel programs to address specific burdens of health and its social determinants.
CASE STUDY FIVE: Professional Midwives in Sri Lanka

With a per capita income of only $2,435 in 2010 according to the World Bank, Sri Lanka has achieved life expectancies for men and women comparable to many developed countries largely by increasing health infrastructure and personnel capacity in rural areas. As the government invested in rural areas, it professionalized midwifery to ensure adequate personnel capacity for an expanded and disparate population. While roughly 96% of all childbirths occur in hospitals today, professional midwives remain a cornerstone of Sri Lanka’s health system. Well-defined requirements, training, and curricula ensure that registered midwives possess a standard skill set. Many midwives live in vacant rooms within local communities, which earns them respect and allows them to offer at-home support to pregnant women. As accepted members of the community, midwives not only dispense services but also link pregnant women to higher levels of care by offering trusted advice to visit antenatal clinics or district health centers. With government support and a steady supply of drugs and equipment, professional midwives continue to help mothers overcome cultural and logistical barriers to accessing care.11

Country Example: Brazil

Brazil has placed special emphasis on maternal and child health ever since the 1980s, when it first implemented a series of programs to address child health and gender inequity. Initiatives to promote breastfeeding and oral rehydration, increase immunization rates, and encourage modern contraception methods have subsequently improved fertility rates and health indicators for women and children. The 1981 National Programme for the Promotion of Breastfeeding trained health workers and mobilized mass media, policymakers, and civil society organizations to improve breastfeeding rates. In 1984 the government implemented the Program of Integrated Care for Women’s Health to ensure women’s sexual and reproductive rights. From 1989-1992 the Women’s Total Health Care Program (PAISM) was established as a pilot project in São Paulo to empower women and introduce different gender perspectives into the health care system as a whole. PAISM was initially managed entirely by female health professionals at the Women’s Health Care Office (WHCO). Today 78.5% of married women use some form of family planning compared to only 57% in 1986, and total fertility rate has decreased from 6.3 children per women in the early 1960s to 1.8 in 2002-2006.12

Although official government statistics show steady maternal mortality ratios (MMR) in Brazil in the last ten years, the UN estimates an actual 4% annual decrease.13 The discrepancy can likely be explained by recent improvements in death registration records, which occurred after the government made investigations into all deaths of women of reproductive age compulsory.
While health initiatives in Brazil have become less targeted at women of late, maternal health indicators continue to improve. The continued progress of female health outcomes following the Community Health Worker program in 1991, the Family Health Programme in 1994, and especially Brazil’s 1988 Unified Health System that aims to provide universal health shows that strengthening the overall health system also promotes safe motherhood.

Even initiatives outside the health sector can improve statistics for women. In 2003 Brazil implemented the Bolsa Família program, which has grown from roughly 3.6 million beneficiaries at its start to 11.3 million in 2009 and is the largest conditional cash transfer program in the world. A family enrolled in Bolsa Família receives regular payments based on per capita income and number of school-aged children. To empower women and increase their influence at home and within their communities, the government dispenses these payments to the female head of household, if possible, on the conditions that she seek basic healthcare, including full vaccination schedules for her family, and keep her children in school. In 2005 93 percent of beneficiaries were females. After the program’s first year of implementation, life expectancy at birth for females jumped from 72.3 years in 1999 to 75.6 years in 2004. Additionally the number of medical appointments increased from 2.29 to 2.45 and the number of hospitalizations per 1,000 people decreased from 7.29 to 6.33. Taken together those numbers suggest that more regular health care can help prevent emergency health shocks, which cause millions of Indians to go into poverty each year. By 2006 31.1% of beneficiaries in ‘extreme poverty’ had moved to ‘poverty’ (per capita income up to R$60) and 4.9% of those in ‘poverty’ had moved out of it. The success of Brazil’s Bolsa Família program reveals the interplay between social conditions and health outcomes, and demonstrates that improving the former can also effectively improve the latter.

Lessons Learned:

- Strengthening health systems generally can lead to improvements in health outcomes for women.
- Conditional cash transfer programs, and other non-health interventions, can be used effectively to provide financial means and incentives for women and families to access and utilize necessary health care.
**Country Example: Thailand**

Though Thailand is marked by considerable inequalities, today those inequalities refer most often to income disparities and less often concern health issues along gender lines. While the average per capita expenditure of Thailand’s richest 10% in 2007 was more than 13 times that of its poorest 10%, 79.6% of girls were enrolled in school in 2007 as opposed to 76.6% of boys and life expectancy at birth in 2008 was 74 for females and 66 for males.¹⁶ In 2008 the under-five mortality rate was 16 per 1000 live births for males and only 12 per 1000 live births for females.¹⁷

Thailand’s considerable success is the result of the government’s commitment to reaching the goals of several international conventions, including the International Convention on Population and Development (ICPD) in 1994 to increase quality of life through population control strategies, the Beijing Declaration in 1995 to eliminate obstacles to female participation in public and private life, and the Millennium Development Goals of 2001 to prioritize female advancement as part of the greater process of development.¹⁸ Soon after ICPD and the Beijing Declaration, Thailand unveiled its Eighth and Ninth National Development Plans (1997-2001; 2002-2006), which included a Population Action Plan and several strategies to empower women. The various initiatives included pilot health care programs for teens, sex education, post-abortion care, premarital counseling, counseling on women’s health including breastfeeding and mother-to-child HIV/AIDS transmission, prevention and treatment of reproductive tract infections, malignancy, infertility, and post-reproductive and old age care.

Although Thailand reports a decline in its maternal mortality ratio from 200 per 100,000 live births in the late 1980s to 45 per 100,000 in the late 1990s, WHO/UNICEF estimate that as many as 110 women died per 100,000 live births in 2005.¹⁹ Despite free universal health care under Thailand’s 2001 National Health Security Act, unsafe abortions remain a problem because abortions are only legal and covered by the government when the life of the mother is threatened or when the pregnancy is the result of rape. A study in 1999 in Thailand revealed that serious complications arise in at least one-third of abortions induced by non-health personnel.²⁰ Although adopting a universal health care scheme is a major achievement for Thailand, the effect will be limited by an incomplete package of benefits for reproductive health services. Thailand faces additional challenges from uneven access to health care and the persistent threat of domestic violence against women.

**Lessons Learned:**
- Participating in, and being signatory to various international conventions can help governments set goals and maintain their commitment to improving health outcomes for women.
- Universal health care coverage can help improve maternal health, but only if a full package of reproductive health services is covered.
SOURCES: