

Gender: Is It A Barrier For Access To Healthcare In India?

IN RESEARCH & PUBLICATION

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ABSTRACT

Background:

In 2005, WHO Member States adopted a resolution to encourage all countries for achieving and/or maintaining universal health coverage without the risk of severe financial consequences. Access to health care is one of the major components of universal health care. Access is complex and multidimensional concept. Gender influence on access and use of health care is one of the key determinants to achieve universal health coverage in India. Men and women both have their health problems. However, it is important to determine whether they get opportunity to solve those health problems. This research aims at studying the gender disparity in accessing healthcare in India.

Methods:

For Literature review analysis, Pub Med, Med Ind, Medline, Embassy, Global health, Social Policy and Research and subsequently Google Scholar were used to identify review articles for gender disparity. A total of 36 articles were included from the above databases alongside separate searches on Google after applying filtration of inclusion criteria. Reanalysed secondary data from NFHS-3 survey is used to identify the reasons for gender disparity. Both the literature review and secondary data were utilised to achieve the aim of this research paper.

Results:

Socioeconomic status, cultural practices, perceptions of illness, cost expenditure on health has significant impact on gender disparity and access to health care in India. Literature review of selected articles and NFHS-3 data identified demand and supply factors which had impact on utilisation of health services in terms of lower immunisation rate or delayed ARI and diarrhoea treatment.

Conclusion: Henceforth, to achieve gender equity in terms of access of healthcare services, it is recommended to encourage female literacy, provide those more employment opportunities, and create awareness about health in community and integration of different medicinal streams.

Chapter I

INTRODUCTION:

The World Health Organisation (WHO) has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Identified by the *2012 World Development Report* as one of two key human capital endowments, health can influence an individual's ability to reach his or her full potential in society (THE WORLD BANK 2012). Gender equality has made the most progress in areas such as education and labour force participation, but health inequality between men and women continues to plague many societies today. Although males and females both face health disparities, it's experienced more by females. This comes from the fact that many patriarchal cultural ideologies and practices have structured society in a way whereby women are more vulnerable to abuse and mistreatment, making them more prone to illnesses and early death (World Health Organisation, 2009).

Subsection (a): Access to health care:

Access is multi dimensional concept which encourages people to utilize health services; within any given social context .Access advantageously uses local knowledge, perceptions, values, relevant traditional practices, preferences and beliefs, to enhance knowledge and awareness. Access is broad concept which not only embraces financial, Institutional and Infrastructure factors, including but also transportation and education. Access relies upon good provider attitude, trust, honesty, responsiveness, accountability and good quality service delivery, both at established facilities and through outreach programmes (Gilson Lucy et al., 2007). If services are available indicating an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent of access depends on financial, Organisational and social and cultural factors that also determine the utilization of services. Utilizations of health services are dependent on affordability, accessibility, acceptability of services. The availability of services, and barriers to access, has to be considered in the context of health needs and cultural settings of diverse groups in society (Gulliford M et al., 2002 July).

Access to health care means "the timely use of personal health services to achieve the best health outcomes" (Institute Of Medicine, 1993). Attaining good access to care requires three discrete steps:

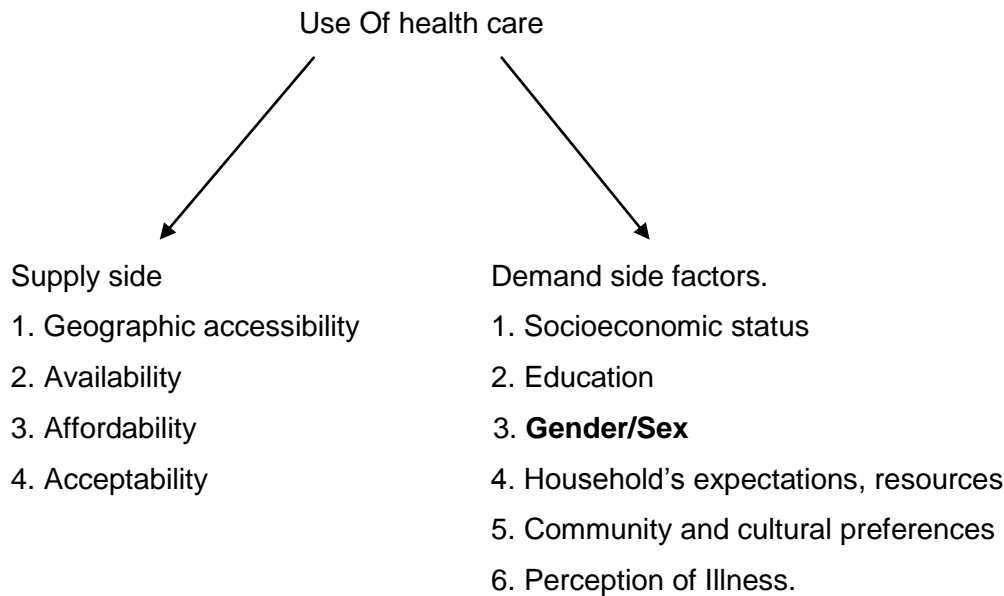
- Gaining entry into the health care system.
- Getting access to sites of care where patients can receive needed services.
- Finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust.

Health care access is measured in several ways, including:

- Structural measures of the presence or absence of specific resources that facilitate health care, such as having health insurance or a usual source of care.
- Assessments by patients of how easily they can gain access to health care.
- Utilization measures of the ultimate outcome of good access to care (i.e., the successful receipt of needed services).

Access and utilization are conceptually different but they are frequently compared quantitatively like provision of facilities or numbers attending health care services (Oliver A and Mossialos E, 2004). Access can be measured in terms of utilization of services or in relation to the 'need' (Donabedian A, 1973). Access to health care is frequently used as a misnomer for mere utilization of health care services, although as explained above access is an opportunity provided to use the health care services. However, keeping in mind the complex relationship of 'access' and 'use' of health care as described above, I have considered use of health care as a way of assessing extent of access to health care.

Use of health care can be determined by demand and supply side factors as below:



Subsection (b): Gender or Sex

At birth, boys outnumber girls with the ratio of 105 or 106 male to 100 female children. However, after conception, biology favours women. Currently Sex ratio of India is 940 females per 1000 males and variations exist as highest in Kerala 1040 and least in Haryana 877 females per 100 (Census, 2011) The ratio of female to male in developing regions such as South Asia, West Asia, and China can be as low as 0.94, or even lower. This deviation from the natural male to female sex ratio has been described by Indian philosopher and economist Amartya Sen. as the "missing women" phenomenon (Sen Amartya 1990). According to the 2012 World Development Report, the number of missing women is estimated to be about 1.5 million women per year, with a majority of the women missing in India and China.

Though the sex is the biological variable; gender is influenced by social and cultural contexts. Despite this, gender has become the norm to describe sex and will therefore be adopted here as well. Gender disparity in various fields like education, work participation rate, average wage rate and participation in political activity is common phenomenon in India which affects overall health of women. Maternal and child health in combination signifies the importance of 'access as indicator of health care' system of any country.

Access to health care services and medicines is one of the major components of universal health coverage. Men and women both have their health problems however it's important to determine whether they get opportunity to solve those health problems.

Subsection (c): India

According to the Census 2011, India's population has crossed the mark of 1.2 billion which is 17% of the entire world's population. In a latest setback, United Nations Development Program's Human Development Report 2013 report shows India at 132nd position out of 187 countries on the gender inequality index. Except Afghanistan, all performed better than India, with Sri Lanka (75) at top. Gender Inequality Index measures the loss in a country's progress and human development because of gender inequality in three sectors:

- Reproductive health
- Women empowerment
- Labour market participation (UNDP, 2013)

The capacity of India's health system is insufficient to address these challenges effectively (Solberg and Kristin Elisabeth, 2009a). Low middle-income countries like India spend small proportion of annual Gross Domestic Product (GDP) on health care (World Health Organisation) where health is responsibility of states. Only 4.9% of India's GDP is spent on health and the majority of this (76%) is out-of pocket or private expenditure, limiting access to health care and pushing people into poverty (Health Systems 20/20, Jul, 2010). Equity is a challenge because health gains such as reduction of mortality; "have seen a highly unequal distribution across regions, and along lines of caste and social status" (Amrith and Sunil S, 2009). "Although world-class health care is readily available for the rich urban elite, the poor struggle to get access" (Solberg and Kristin Elisabeth, 2009b). In 2005, WHO Member States adopted a resolution to encourage all countries for achieving and/or maintaining universal health coverage without the risk of severe financial consequences.

India's health system is organised hierarchically. The majority of disease control programmes are organised by central government and operate vertically (Central Ministry of Health and Family Welfare). Individual states have autonomy to decide how to allocate funds according to the priorities; but their health policies are influenced significantly by the central (federal/union) Health Ministry (Gupta Das Monica et al., 2009). Inequalities are

pervasive in the availability of public health services in the rural and urban areas and across the states. Variations are pronounced in terms of infrastructure, human resources, supplies, bed-population ratios and spatial distribution of health institutions. The utilization of preventive services such as childhood Immunisation and ante-natal care (ANC) are effective indicators for assessing the equity of use of health services (Shiva Kumar A.K et al., 2010).

Millennium Development Goals 3 & 4, 5 were based on promotion of gender equality and women empowerment and to eliminate gender disparity in education, and reduction of child, maternal mortality. Strategic theme of National Population Policy 2000 was based on empowering women and for improved health and nutrition, which has major impact on health status of women and society as a whole. Recent health system reforms in India largely focus on the allocation of services in undersupplied areas and the extension of financial protection to the poor. The Constitution of India ensures gender equality in its preamble as a fundamental right. By ways of a number of legislation and policies government adopted many measures of positive discrimination in favour of women. India has also ratified various international conventions and human rights forums to secure equal rights of women, such as ratification of Convention on elimination of all forms of discrimination against women in 1993. Women have been finding place in local governance structures, overcoming gender biases. Over one million women have been elected to local panchayats as a result of 1993 amendment to the Indian Constitution requiring that 1/3 rd of the elected seats to the local governing bodies be reserved for women. The passing of Pre-natal Diagnostic Tech Act in 1994 also is a step in removing gender discrimination. This Act seeks to end sex-determination tests and female feticide and prohibits doctors from conducting such procedures for the specific purpose of determining the sex of the foetus. The Government also announced the National policy for empowerment of women in 2001 to bring out advancement, development and empowerment of women.

Females usually have the crucial role of caretaker in every Indian home. Some recent health reforms have done little to break down the health barriers that exist for female gender in achieving better health. This study attempts to find these gaps by reviewing the

literatures based on gender and their utilization of health care pattern with supporting secondary data from national family health survey-3.

Subsection (d) Aims and Objectives:

Research question:

Whether gender difference affects the access to health care services in India and to what extent?

Aims and Objectives:

1. To assess the extent of gender influence on access to health care in India.
2. To review the literature and identify the reasons affecting the access to health services (demand-side and supply side factors).
3. To identify the demand factors by analysing secondary data (NFHS-3)
4. To discuss the wider Implication of the results on access to health care from a policy perspective.
5. To make recommendations about potential areas of policy intervention.

Chapter II METHODS:

Literature review:

- a) To assess extent of gender Influence on access to healthcare services.
- b) To find the reasons affecting the access to health care services.

Literature searches were carried out using keywords in three areas:-

- **gender and health** in combination with key words such as 'access to health, 'healthcare access' 'health services geographic accessibility', 'delivery of health care ', ' availability of health services ', 'programme accessibility 'were used.
- The term India combined with terms such as 'gender 'and 'Access to health'.

Following databases were searched: MedIND, Pub Med, Medline, Embase, Global health, Social Policy and Research, Google Scholar used to identify review articles of gender disparity In relation to access for health care written in English. On different data bases, 1693 articles were identified by combining 'access' related keywords and 'India'. However,

only 46 were found by combining third key word as 'Gender' or 'gender disparity'. After thorough inspection of all abstracts, 14 papers were selected for further analysis. All others were either not in review articles or focused on different topics. Subsequently, 13 more articles selected from the bibliographies of retrieved papers alongside separate searches on Google Scholar for all three categories. Thus in total 27 articles were reviewed thoroughly to meet the aims and objectives of the research along with the 09 papers from grey literature searches on Google included Government reports, demographic and health surveys, working papers and reports by development agencies, inter-governmental Organisations and prominent voluntary bodies. Ethical approval was not required as data from public domain was used.

Inclusion criteria

Concerning gender and health, vast array of wider public policy, disease specific/genetic literature was available, only broader health outcome and access policy papers related to gender were included. To get the complete picture, both urban slum and rural studies were included in review. Studies published after 1990, were considered, just to ensure that the findings are comparable over the longer period of time.

Analysis of secondary data

Analysis of secondary data National family health survey-3 was done to find the reasons behind gender disparity and support the evidence collected from literature review. National Family Health Surveys-3 (NFHS) was conducted in 2005-2006 and published in September 2007 (International Institute For Population Sciences (IIPS) and Macro International, 2007).

Considering the vast data availability in public domain and complex nature of interaction between socio-economic factors and access to health care; to limit the searches, I have stressed 'gender disparity' and 'access to health care' as major key words for this study. The overview of the types of determinants studied, their suggested pathways and the typical findings are comprehensive. The breadth of topic, its context-specificity, lack of comprehensive index terms and the vast differences in methodology employed, rendered the option of doing as systematic review of this literature was impractical. Gender

discrimination is deeply entrenched in Indian society; it was felt that substantial changes could only be measured over a period of time. This is an attempt to review its impact on access to health care in India.

Chapter III RESULTS:

IIIa. Evidence from literature review:

To assess the extent of gender influence on use of health

Several authors (Shiva Kumar A.K et al., 2010, Kundu Soma, 2010b) used the utilization of preventive services such as childhood Immunisation and ANC as effective indicators for assessing the availability, accessibility and quality at the primary level of health services. The overall Indicators for full Immunisation are poor in India with variation across rural and urban areas; states and socio-economic groups.

National Sample Survey Organisation (NSS) did not reveal significant gender bias in access to health care facilities by women. In most of the states, the proportion of girls immunized in rural areas was about 1 to 2 per cent less than the proportion of boys immunized. At the all India level, the proportion of children receiving Immunisation was same in both the sexes in rural areas. On the contrary, the National Family Health Survey provided the data with significant gender bias regarding the percentage of children between 12 to 23 months receiving Immunisation. Girls (42 per cent) were less likely than boys (45 per cent) to be fully vaccinated. Table 3.1 explained the lower utilization of preventive services like immunisation by female children.

Table 3.1: Gender Disparity in Percentage Distribution of Children of Age 12–23 Months Receiving Any Immunisation (2005–06)

Sex	BCG	DPT			Polio				Measles	All vaccinations
		1	2	3	0	1	2	3		
Male	80.2	78.4	69.2	57.4	50.4	94.1	89.5	79.3	61.4	45.3
Female	75.8	73.2	63.8	53	46.2	91.9	88	77.1	55.8	41.5

Source: NSS 2006 (Kundu Soma, 2010a)

Mathew (Mathew Joseph L, 2012) analysed NFHS 1,2 and 3 survey data suggesting that ,overall gender disparity did not increased over the time. The overall girl to boy vaccination coverage ratio was 0.95 for India as a whole. The 2009-10 UNICEF survey reported complete vaccination in 61.9% boys and 59.9% girls.

Employment and child Immunisation Children whose mothers were employed have lower full Immunisation rates (32%-42%), than children whose mothers are not employed (47%). Among children with employed mothers, the full Immunisation rate and gender differential was dependent on mother's control over earnings. Children whose mothers earn cash and have the main say alone in the use of their earnings have a higher full Immunisation rate, at 42%. However, the gender differential favours girls if the mother earns cash and has a joint say in its use (NFHS-3).

Participation in decisions and child Immunisation Sunita (Sunita Kishore and Kamla Gupta, 2009) studied decision making participation in household earnings and its impact on children immunisation. Children who have the highest Immunisation rate are those whose mothers make decisions jointly about their husbands' earnings, their own health care, and visits to their family and relatives, and make decisions alone about large purchases and purchases for daily needs. For most decisions, children of mothers who have no main say are the ones least likely to be fully immunized. Gender differentials in Immunisation also vary by mothers' participation in household decision-making. The gender differential in Immunisation favours girls if the mother alone has the main say in how her husband's earnings are used, although this is the same group for whom the Immunisation rates are less than for any other group of children.

Women's experience of spousal violence and child Immunisation Authors of IIPS study (Sunita Kishore and Kamla Gupta, 2009) tried to explain the impact of spousal violence on children immunisation. Children of mothers who are free from spousal violence have a higher full Immunisation rate (46% if the mother has not experienced any emotional violence and 50% if the mother has not experienced any physical or sexual violence) than children whose mothers have experienced violence (34-35%). A mother's experience of violence has a much stronger negative association with a girl's likelihood of being fully

immunized than with a boy's likelihood of being fully immunized. 61 % fully immunized daughters are found compared to sons (82%) where mothers have experienced emotional violence.

Acute Respiratory Infection and Diarrhea Treatment:

Treatment sought by the families (Ganatra B et al., 1994) in 77.8% of episodes of illness, with no apparent sex bias. However, after detailed analysis of children for whom treatment was sought showed a significantly higher proportion of girls (18.8%), compared to 6.7% for boys who were taken for treatment to a paramedical worker (auxiliary nurse-midwife or multipurpose health worker). On the other hand, a significantly higher proportion of boys (88.9%), compared to 76.5% for girls were treated by a registered private practitioner. This difference persisted even after adjusting for severity of the illness.

Table 3.2: Gender Disparity In Treatment of Symptoms of Acute Respiratory Infection (ARI) of Children below 5 years of age (2005–06)

Sex	% for whom treatment was sought	% who received from a health facility or provider antibiotics
Male	71.7	13.2
Female	65.8	11.7

Table 3.3: Gender Disparity in Treatment of Diarrhoea in Children below 5 years of age (2005–06)

Sex	% for whom treatment was sought from health provider	% given Increased fluids and continued feeding	% given ORT and continued feeding
Male	61.6	7.7	33.9
Female	57	7.2	31.2

Source: NSS 2006 (Kundu Soma, 2010b)

Tuberculosis:

India has the highest tuberculosis (TB) burden, according to World Health Organisation (WHO) statistics for 2011. India had estimated incidence of 2.2 million cases of TB out of a global incidence of 8.7 million cases. The estimated TB prevalence figure for 2011 was given as 3.1 million (Global Tuberculosis Control, 2012). It is estimated that about 40% of Indian population is infected with TB bacilli, the vast majority of whom have latent rather than active TB. Henceforth Tuberculosis can provide better picture of gender disparity in reference to utilisation of health care services.

Many authors have tried to establish linkage between health seeking behaviour of TB treatment with gender disparities (Balasubramanian R et al., 2004). This study explained notification and treatment received by women more than men. This was confirmed with number of women of all age groups except above 65 year, visiting health facilities outnumbered than men. Tuberculosis patients registered for DOTS, the M: F ratio was 2.7 and increased with age. Women were more likely than men to first consult private provider. Females were most likely to visit non-qualified private providers (Iyer Aditi et al., 2007). The M: F ratio was 6.5 among smear-positive patients detected in the community survey compared to 4.1 for those notified at health facilities. Previous community based prevalence surveys conducted elsewhere in India have also found high M: F ratios ranging from 1.6 to 5.4. Author also revealed the fear of rejection among respondents. Married women expressed fear of rejection from husbands and harassment by in-laws. The parents of young women were likely not to reveal that their daughter has TB. They were in favour of not sending them for directly observed treatment (DOT) due to difficulties that may arise in marrying them off. All males and females aged below 45 years in study felt equally inhibited in discussing their illness with family or friends or attend social functions. But reporting of patients diagnosed in the private sector was not notified to government facilities which might have significant impact on the study results.

Malnutrition:

Using World Health Organisation (WHO) 2006 Child Growth Standards, NFHS-3 found that 40% of children ages 0-35 months were underweight, with girls and boys equally likely to be underweight. But where there is no main say in health of women, females are slightly more underweight the body mass index (BMI), a measure derived from the ratio of the

weight and height of individuals, is a widely accepted indicator of the nutritional status of adults. A BMI of less than 18.5 indicates chronic energy deficiency associated with being too thin. NFHS-3 shows that 36% of all women age 15-49 in India have a BMI of <18.5, only somewhat more than men in the same age group (34%).

Cardiovascular Diseases

The little available data from Chow study (Chow C.K and Patel Aa, 2012) suggested that Indian women in rural areas, younger women and girl children with CVD are less likely to receive appropriate management than men, with this disparity most apparent in those of lower socioeconomic status and education.

Renal transplant

Retrospectively analysis of all Living Donor (LD) renal transplantations performed at a single centre between 2001 and 2005 was done by two authors (Bal M M and Saikia B, 2007). Of the 682 recipients, 606 (88.9%) were males and 76 (11.1%) were females ($P < .0001$). There were 552 biologically related, 118 spousal, and 12 unrelated no spousal donors. Among the donors, there were 451 (66.1%) females and 231 (33.9%) males ($P < .001$). Most of the live donations were contributed by mothers (32.1%). In the spousal group, the greatest gender disparity was observed with predominantly wives donating for their husbands (90.7% vs. 9.3%). Complex social and economic factors are responsible for the overall gender imbalance. In conclusion, women represent a highly vulnerable group in LD renal transplantation.

Cognitive function

Lee (Lee J et al., 2014) reported gender disparity in cognitive function in India, and this disparity is greater in the north than the south. They also found that gender disparities in educational attainment, health, and social and economic activity explain the female cognitive disadvantage in later life.

III (b) Evidence from literature review:

To identify the reasons behind gender disparity affecting access and the use of health care in India

Demand side factors: 1. Socio-economic and cultural factors:

Cultural norms and practices are two of the main reasons why gender disparities in health exist and continue to persist. These cultural norms and practices often influence the roles and behaviours that men and women adopt in society. It is these gender differences between men and women, which are regarded and valued differently, that give rise to gender inequalities as they work to systematically empower one group and oppress the other. Both gender differences and gender inequalities can lead to disparities in health outcomes and access to health care. Some of the examples provided by the World Health Organisation, how cultural norms can result in gender disparities in health include a woman's inability to travel alone, which can prevent them from receiving the necessary health care that they need. Another societal standard is a woman's inability to insist on condom use by her spouse or sex partners, leading to a higher risk of contracting HIV (World Health Organisation).

One of the better documented cultural norms by Lena (Edlund Lena, 1999), that augment gender disparities in health is the preference for sons. In India, for instance, the 2001 census recorded only 93 girls per 100 boys. Several authors (Das Gupta M et al., 2003) expressed concern as sharp decline from 1961, when the number of girls per 100 boys was nearly 98. In certain parts of India, such as Kangra (Himachal Pradesh state) and Rohtak (Haryana state) the number of girls for every 100 boys can be as low as in the 70s. Additionally, low female to male numbers have also been recorded in other Asian countries – most notably in China where, according to a survey in 2005, only 84 girls were born for every 100 boys. Although there was a slight increase from 81 during 2001–2004, it is still much lower than the 93 girls per 100 boys in the late 1980s (Kishor S and 1993). The increasing number of unborn girls in the late 20th century has been attributed to technological advances that made pre-birth sex determination, also known as prenatal sex discernment, such as the ultrasound test more affordable and accessible to a wider population. This allowed parents who prefer a son to determine the sex of their unborn child during the early stages of pregnancy. John (John M et al., 2008) tried to establish the

connection between female foeticide and early prenatal sex detection. Additionally, the culture of son preference also extends beyond birth in the form of preferential treatment of boys. This preferential care can be manifested in many ways, such as through differential provision of food resources, attention, and medical care. Study data from household surveys (Arnold F et al., 1998) over the past 20 years has indicated that the female disadvantage has persisted in India.

Balagopal (Gayathri, November 2009) mentioned health care utilisations is mainly affected by 'financial constraints'. Although treatment in public health facilities is free of cost, but there are indirect costs involved like expenses on transport, food and bribes. Many people have to use transport to access the healthcare facilities which were located 2-3km away from their residences. The evidence showed that the poor and socially marginalised get the least access to preventive and curative health services.

Evidence of pure gender bias, in terms of no treatment proportion for women was higher in all expenditure quintiles compared to men (Iyer Aditi et al., 2007). In general, all women suffered from the consequences of gender bias, but in particular poor women disproportionately bear the burdens of both gender and economic class. Non-significant caste differences imply that basic access to health care in such a context was a function of poor purchasing power. Responses to long-term ailments showed the elements of class inequalities as well as gender bias.

Subramanian and others (Subramanian S V et al., 2006) found that young children between aged 2–5 years especially girls were facing the widespread gender difference in nutrition and in intra-household distribution of resources including food, access to medical treatment and parental care.

The national level NSS data (Shiva Kumar A.K et al., 2010) to explain that untreated morbidities were higher for the following groups: Rural versus urban; females versus males; Scheduled Castes (SCs) and Scheduled Tribes (STs) versus forward castes; and lower consumption classes versus the higher ones. Women belonging to the SCs and STs had much poorer access to healthcare compared with men and women belonging to the other castes and classes.

NFHS-3 re-analysed data (Mathew Joseph L, 2012) which showed, poor child health was mostly concentrated in poor households; and the highest impact of increasing average immunisation coverage rates occurred in healthier households. The survey carried out in the state of west Bengal also evaluated the impact of standard of living. Complete vaccination was 44.6% among those with low standard of living, 58.0% for medium standard; and 77.1% with high standard of living. In another study of children in 1-2 years old, residing in rural areas, the proportion of complete immunisation was 45% in poor households and 55% in non-poor households.

Study on long-term ailments lasting for two years on an average, suggested gender and economic class differences in treatment-seeking, but no significant caste differences were found (Iyer Aditi et al., 2007). More women than men had never treated their illness, among both poor and non-poor groups. Class differences in non-treatment were apparent among women, but rarely among men. However, treatment being discontinued despite persistent ill health seemed to vary by economic class for both men and women. Households spent significantly smaller sums on the treatment of women than that of men in all quintiles except in the poorest. Women were three times more likely than men to never treat their illness; the poor were 1.55 times more likely to never treat than the non-poor. Compared to non-poor men, poor women were four times more likely to never seek treatment; even non-poor women were twice as likely to never treat. In contrast, poor men were not significantly different from non-poor men.

Gender discrimination across the spectrum of paediatric healthcare including emergency, inpatient, outpatient and preventive care and is mostly reported from South Asia and China with sporadic reports from Africa and South America (Khera R et al., 2013). Biases against young girls have been documented even in immunisation percentage, home food allocation, seeking medical care for childhood ailments and percentage of household healthcare expenditures allocated to them. Such gender discrimination in access to medical care is likely to have an influence on the overall health of female children.

Linkage between gender and women employment status reflected its association with use of health care services (Gill R and De S 2011). Consequently, it has affected the women's capacity to access and use maternal health services, a critical component of maternal

health. Still, family planning is typically viewed as the responsibility of women, with programs targeting women and overlooking the role of men—even though men's dominance in decision making, including contraceptive use, has significant implications for family planning and access to reproductive health services.

2. Perception of Illness:

Perception of illness was common factor found in selected articles as a confounding factor for not seeking treatment at health facilities. This attitude usually transformed into behaviour as not accessing to health care when needed. This was persistent with women regardless of their age and severity of illness.

Perception of diseases emerged most common reason among the all other reasons cited for untreated ailments (Gayathri, November 2009). Most of the elderly men, who gave reasons for illness being left untreated, either perceived the ailment as not serious, or said they could not afford treatment. However, most of the elderly women reported other reasons for not taking medical treatment. The 'Other' reasons cited for not seeking treatment included disease being a part of old age; the burden of care giving responsibility at home; the fact that people had a medical appointment coming up; physical immobility; poor eyesight which prevented them from using public transport to get to the clinic; or because of home remedies .

Perception of ante-natal care (ANC) is important determinant for health and access to health care. Although urban women exhibit awareness of availability of ante-natal care, and report using services because they are more beneficial to health. Two authors (Griffiths Paula and Stephenson Rob, 2001) reviewed perception of the potential health benefits of ante-natal care .Number of women who were non-service users in urban areas (4/26) and rural areas (8/19) reported that, they did not perceive antenatal care to be beneficial to their health, or the health of their unborn child. Among these women, antenatal care was viewed as a curative rather than preventive form of care. Respondents indicated that pregnancy was a natural state there was no need to seek medical care, and such care should only be sought if an obvious problem arises. Therefore, there is still a scope for improvement in content, providing more information on the potential benefits of antenatal care.

3. Urban-Rural settings:

The inter-state variation in urban and rural setting in terms of immunisation and ante-natal care received have wide gap (Shiva Kumar A.K et al., 2010). All India rate for receiving full ANC stood at 51% of women in 2005-06, with a rural-urban differential of 43% and 74%, respectively. In the same year, full immunisation coverage in state of Kerala was 94% with a rural-urban coverage of 92% and 97%, respectively. However in Uttar Pradesh, it was merely 26%, with the rural-urban differential of 23% and 41%, respectively. This indicates wide interstate variation in utilisation of preventive services in India and inability to access the health care by rural population.

Hospitalisation rates varies in both urban or rural settings (Contractor Qudsiya, 2008) . These involved considerable expenses, disruption of the routines of several individuals (including the patient and carers, as well as those who must stay back at home to look after survival needs), indebtedness and emotional stress caused by the serious illness of loved one. Among the compelled hospitalisations within a year after the urban slum resettlement, there appeared to be a gender difference in the pattern of illnesses reported for males and females. On categorising the reasons for hospitalisation, females were hospitalised more often for chronic problems or acute episodes of chronic problems. About one-half of the hospitalisations among females were for such problems. This signifies delayed health seeking behaviour by females. Males, on the other hand, were hospitalised more often for accidents and sudden illnesses.

Supply side factors

1. Absence of Health Insurance/ Out of pocket Expenditure on health

Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure. From 2008-2012, India is spending overall 86 % of

private expenditure on health (World Health Organisation-National Health Account database).

Absence of health insurance, non affordability was the main reason cited by participants for not seeking ante-natal care (Griffiths Paula and Stephenson Rob, 2001). In each of the areas studied, despite free care availability at public hospitals, those women who did not receive antenatal care reported that they could not afford to seek care. After detailed analysis, authors found that the use of a service can incur both direct costs, in the money needed to pay for the service and transport to reach the facility and indirect costs, in the form of the loss of the time from household duties. However, the costs associated with private health care were highlighted as a barrier for utilisation of health care.

The average total cost of treating each ailment or illness was approximately \$7.2 in private health facilities and \$0.4 in public health facilities (Gayathri, November 2009). While the treatment expenditure was higher for elderly men, it must be noted that their access to economic resources would be higher than that of elderly women, as they would have access to paid employment opportunities. Participation in income earning work was higher among elderly men (31.1 per cent) than elderly women (14.3 per cent). For the elderly who receive social security benefits like the Old Age Pension, it was hard to say whether that amount was sufficient to meet their health care costs; particularly in the private health sector, for chronic conditions, which involve long-term treatment and the regular use of diagnostic tests.

However, there were several National Programmes targeting women in the reproductive age group and children as the beneficiaries for access to free antenatal and postnatal care for women and provision of free immunisation and midday meals to children. Considering the nature of ailments suffered by the elderly, Government of India has to go a long way to achieve universal health coverage.

2. Public –private sector:

The National-level data on private health facilities for outpatient treatment, with 78 % and 81 % of illness in rural and urban areas, respectively (Gayathri, November 2009).The pattern of using private or public health facilities displays a marked variation by gender. More than half of ailments among elderly men were treated at private health facilities (58.1 per cent), whereas most of the ailments reported by elderly women were treated at government health facilities (64.6 per cent).

Three most common reasons as, “not satisfied with medical treatment” followed by “lack of availability of services” and “long waiting” for not utilising health care services were mentioned in study (Shiva Kumar A.K et al., 2010). However, other authors had slightly different findings (Ganatra B et al., 1994). Free health care facilities and services were utilized in 11% of the female children and 3.3% of male children, and no money was spent on medicine, transport or consultations. The chance of seeking medical advice from a private practitioner was 2.5 times greater for boys than for girls. The initial provider of choice by study participants were private doctors regardless of any gender (Ganapathy Sudha et al., 2008.). Private hospitals chosen by respondents, for childbirth despite its higher cost was mainly due to the perception of good quality treatment. Either it signifies the poor quality of care provided in government facilities or it could be overprovision of care or unnecessary prescribing medicines at private health facilities.

Most women participants continued to go to nonqualified quacks for treatment, adding to the costs and efforts to seek treatment (Contractor Qudsiya, 2008). This also tends to act as a deterrent for women in need of medical treatment. They tried to deal with their illness by taking painkillers or medicine given out by chemists/pharmacist based on a brief description of the symptoms .Inadequate services provided by the state and the unregulated proliferation of unqualified private health providers forces households to spend more on treatment and also raises concerns over the quality of the treatment sought from such providers.

Study (Iyer Aditi et al., 2007) on different health facilities revealed more use of government health workers/institutions by poor men than poor women, while non-poor

respondents used private health facilities more than poor. The most popular providers overall were RMPs/private practitioners (RMPs are registered medical practitioners). Many of the RMPs/private practitioners were unqualified, but could not estimate exact number as most of them were unaware of their valid degree status. Other unqualified practitioners such as healers and storekeepers were used less frequently by all except the poorest women.

3. Distance from health care centre:

Geographical accessibility is one of the determinants used to assess the access to health care. National rural health mission (NRHM) - National report, 2009 surveyed all Primary health centres (PHCs) by public transport. Average distance to reach PHC from nearest Health Sub Centre (HSC) was 5 km and it varied from 21 km in Arunachal Pradesh and Kerala to 01 km in Daman Diva and Delhi. Its impact on access to health care is visible in following studies.

The ICMR survey (1999) report which showed complete vaccination coverage in only 19% infants living in small (population<500) villages located more than 5 km away from health centres. In contrast, villages located within 1 km of a health-care centre had 56.9% coverage. However, some villages despite having proximity to the health centre, vaccination coverage was low (Mathew Joseph L, 2012).

Boys were favoured more than girls when there was a need to travel a long distance for receiving medical treatment (Ganatra B et al., 1994). Parents had more preference for sons than daughters, twice as likely to travel outside the village for medical care and about 3.7 times as likely to spend more for treatment. If referral for further treatment was advised, it was 6.8 times more likely to be availed for sons. Distance from households to health care centre had impact on access to health care especially on girl's health.

The distance required to travel to reach government facilities criticised for lesser utilisation of services (Griffiths Paula and Stephenson Rob, 2001) (Contractor Qudsiya, 2008) Women respondents choose nearest available private hospitals for childbirth, although they would prefer to use government facilities if they were available in proximity. Some of

the health facilities without operational lifts were more difficult for them to use. The longer distance and lack of a family member to accompany sick family member was also mentioned as a reason for not being able to seek treatment.

III (c) Evidence from National survey (NFHS-3) data supporting the gender disparity

Gender equity is considered as a goal of health policy but one might have difficulties to understand what exactly it means. Horizontal equity mean equal treatments for equals and vertical equity being unequal mean unequal treatment for unequal. From broader perspectives, gender equity might be considered equivalent to equitable distribution of health related resources. However, needs and problems are different for men and women. This requires careful insight into the socio-economic and cultural aspects of the society. Four specific indicators were used by NFHS 3 survey to evaluate gender equity as below:

- 1) Ratio of girls to boys in primary, secondary, and tertiary education
- 2) Ratio of literate women to men 15-24 years old
- 3) Share of women in wage employment in the non-agricultural sector
- 4) Proportion of seats held by women in national parliaments

From above all, First 3 Indicators can be very well explained in Table 3.4, 3.5 and 3.6 as below:

Table 3.4 Gender Disparity in Literacy

Age	Sex	Literacy rate (%)	Gender Disparity
15-49	Male	78	29%
	Female	55	
20-24	Male	84	23%
	Female	64	
15-19	Male	89	17 %
	Female	74	

Table 3.5: Gender Disparity in Higher Secondary School Completion

Age	Sex	% with 12 years of schooling	Gender disparity
15-49	Male	20	39%
	Female	12	
25-29	Male	23	36%
	Female	15	
20-24	Male	27	29%
	Female	19	

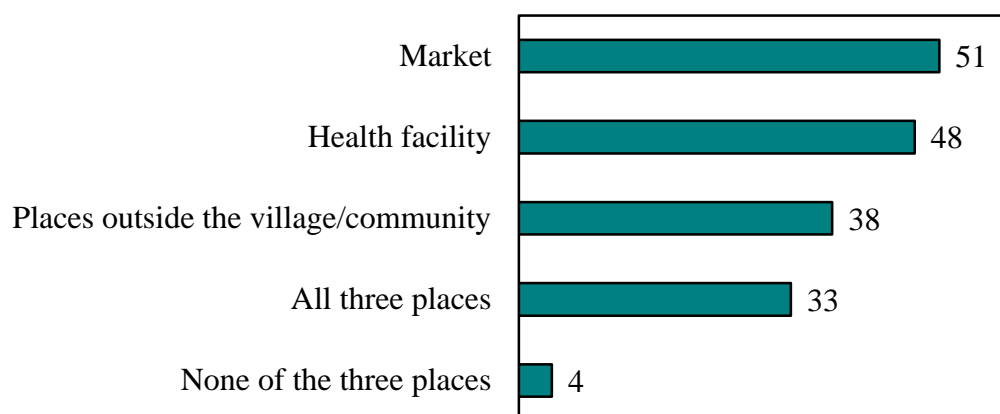
Table 3.6: Gender Disparity In employment

Percentage of	Men	Women
Employed	87	43
Employed for cash	79	29

Source: NFHS-3 data

Among 15-49 years age group, men were twice as likely to be employed and 2.7 times likely to be employed for cash.

Graph 3.1: Percentage of women age 15-49 who is allowed to go alone to



Source: NFHS-3 data

Table 3.7: Participation of women in other household decision-making

Decisions	Make decisions alone or with husband jointly
Own health care	62
Making major household purchases	53
Making purchases for daily household needs	60
Visits to her family or relatives	61
All of the four	37
None of the above	21

Source: NFHS-3 data

Besides the literacy and employment, data showed in Graph 3.1 and Table 3.7 determines the decision making power of women and men. NFHS-3 asked married employed women and men who controlled their own earnings and who controlled spouse's earnings (if relevant). Only one-third could travel alone to all three destinations: the market, health facility and outside the village or community.

Older women were much more likely to participate in household decisions. However, less than half of even the oldest, urban, more educated, employed or healthier women participate in all four decisions. NFHS-3 data clearly indicated gender disparity in terms of basic social and cultural aspects of society which had major impact on health care seeking behaviour of women.

Chapter IV

DISCUSSION:

'Fourth World Conference on Women' (UNITED NATIONS, 1996) asserts that both men and women have the same right to achieve the highest level of physical and mental health. However, women are disadvantaged due to social, cultural, political and economic factors

that directly influence their health and impede their access to health-related information and care. In World Health Report (World Health Organisation, 2008) strategies to improve women's health particularly related to gender inequality were discussed. Additionally, socioeconomic and cultural barriers that hamper women in protecting and improving their health must also be addressed.

According to the World Health Organisation, approaches and frameworks that are being implemented to address gender disparities in health acknowledge the fact that majority of the care work is provided by women. The importance of women, in both the household and the larger community is largely felt as they play critical roles as caregivers (Wallerstein N, 2006). Meta-analytical study of 40 different women's empowerment projects (Manandhar DS et al., 2004) found that increased female participation has led to a broad range of quality of life improvements. These improvements include increase in women's advocacy demands and Organisation strengths, women-cantered policy and governmental changes, and economic conditions for lower class women. Utilisation of health care services is dependent on demand and supply side factors. Literature review and secondary data analysis from NFHS 3 identified some evidences supporting the gender disparity in utilisation of health services as discussed below:

A) Extent of inequity

Several authors (Kundu Soma, 2010b, Ganatra B et al., 1994) suggested decrease in immunisation rate, diarrhoea and ARI treatments in girls compared to boys. Birth order, urban and rural habitation were confounding factor for gender bias in immunisation coverage. The evidence of gender disparity from literature review was supported by NFHS-3 data. However, there was no obvious gender difference in utilising health services in tuberculosis screening treatments (Balasubramanian R. et al., 2004).

Analysis of the three NFHS rounds showed that although higher birth order infants had lower vaccination coverage, girls were particularly disadvantaged. Among third birth order infants with two older sisters, only 36.1% girls received age-appropriate vaccination compared to 45.0% boys. However, third birth order girls with two older brothers had slightly higher rates than boys in the same situation (Mathew Joseph L, 2012).NSS data did not reveal remarkable disadvantage for female children, but NFHS-3 revealed gender disparity. This may be due to the fact that NSS provides data regarding immunisation of

children, who were 0–4 years of age, while NFHS-3 (2007) provides data regarding immunisation of children who were 12 to 23 months of age. Therefore it can be safely assumed that in very early childhood female children were more disadvantaged. Inhibition felt by both male and females for TB treatment indicated stigma- related issues which need to be addressed for both men and women. Access to health care services was unlikely to be a factor for the lower case notification among women in this setting because far more women than men attended the Peripheral Health Institutions (Iyer Aditi et al., 2007).

B) Demand and supply factors: Affordability of services:

It is evident from World Bank data that Indian population is paying almost 84 % out of pocket (OPP) on health. In absence of social health insurance, lower socio-economic class transfers the burden to weaker section that is women. There are some government policies which provide financial protection through insurance and conditional cash transfers. But, little has been done to analyse the main sources of health related impoverishment that are linked to frequent outpatient visits, drug purchases and indirect costs of health care . Monitoring of cash flow and problems of corruption, scams are conveniently neglected. Several authors (Iyer Aditi et al., 2007, Gayathri, November 2009) have cited inability to afford health services as most common reason for barrier to health care access . Families spent more money on the treatment of their sons than daughters.

Survey carried out by Transparency International, explained that, 30% of patients in government hospitals had to pay bribes or use the influence to jump queues for treatment and for outpatient appointments with senior doctors, and to get clean bed sheets and better food in hospital. On the other hand, enormous growth of private sector accounts for 82% of outpatient visits, 58% of inpatient expenditure, and 40% of births in institutions (Sengupta Amit and Nundy Samiran, 2005). Factors like bribe, expensive care provided at private infrastructure, unregulated non qualified private practitioners had synchronising effect on poor access to health care (Iyer Aditi et al., 2007, Contractor Qudsiya, 2008).

Availability of services:

Inequalities were strikingly evident in the availability of public health services in the rural and urban areas and also across the states. Variations were pronounced in terms of infrastructure, human resources, supplies, bed-population ratios and spatial distribution of health institutions. The rapid rise in private healthcare in Kerala was mostly due the investment in basic services by the state government. Kerala study has further highlighted the role of the state in investment in terms of social development, even for low per capita income families. (Shiva Kumar A.K et al., 2010). These strategies achieved improvements in the health, which were comparable to those in middle and high income countries.

Public health policies that revealed geriatric care has been neglected so far (Gayathri, November 2009). There were no specific policy prescriptions regarding health care provision for poor elderly women, unlike women belonging to the reproductive age group, and it might be due to the low cost-effectiveness of elderly patients treatments.

The rapid process of urbanization has seen as an explosion of "slums" worldwide. These slums with peculiar overcrowding feature pose a threat to healthy life through generating the physical, social or economic constraints. Urban slums were characterized as unplanned informal settlements where access to services was minimal. Urban settings and in particular the health challenges of slum dwellers constitute a vast and growing challenge, particularly countries like India with second highest populations in world.

The lack of transport and long distance travel that is often associated with reluctance in seeking care especially among elderly females, which was evident in both rural and urban population. NFHS 3 survey and several studies (Griffiths Paula and Stephenson Rob, 2001, Shiva Kumar A.K et al., 2010) revealed that people were not at all satisfied with government facilities. This was mainly due to under staffing, overburdened health services, lack of monitoring and less payments/salary which triggers corruption undermining the quality of care. Conversely, it necessitates capacity building which can only happen if there will be training and jobs to incorporate practitioners of other medicinal systems like herbal, ayurvedic or homeopathic. However Indian government started AYUSH programme which provides the opportunity to these medicinal system to work in government but they are not legalised to practice allopathic medicines. Considering health care seeking behaviour of

Indian population and their tendency towards allopathic stream, it is futile attempt to include them in main stream.

Utilisation of services:

Most strategies focus only on the public sector, while the role of the private sector and its regulations poorly defined. It is more focused on rural areas and less developed states creating more rural-urban and inter and intra-state inequities.(Baru Rama et al., 2010).It can be explained very well with NRHM implementation which started way back in 2005 and NUHM launch news in last September (NUHM, 2013) after the gap of 8 years.

Cultural practices are deeply entrenched in Indian society. The preference for sons and other local customs directly influence the health status of females, including the utilization of health services and child survival technologies on behalf of girl children. Families are likely to deny health care services for daughters if there is or need of referrals to higher level of care or higher treatment money involved (Ganatra B et al., 1994, Kundu Soma, 2010b) .Similarly, maternal health care utilisation is greatly influenced by cultural norms, socio-economic status and importance of health care awareness. States like Punjab and Haryana, where patriarchal norms are very strong, the proportions of children covered for immunisation were closer to the levels of utilisation. In Tamilnadu, Kerala and Goa, yet percentage of women covered by all recommended ANC services is less than half compared to those states (Ariokisamy Periaaygam and Pradhan Jalndhar, 2013) .Majority of women prefer home remedies or neglect health as they perceive male being earning member should get priority (Ganapathy Sudha et al., 2008.)

Literature review and NFHS-3 data supported the lack of opportunities to females for access and utilisation of health care services in India. These opportunities were limited mainly due to the existing cultural practices and social norms which explicitly indicates financial dependability of women on earning male member of family. Limitations of my study and relevant policy suggestions explained in later part.

Chapter V

V (a) Limitations of Study:

No effort was made to pool data through meta-analysis, as the objective was to explore factors associated with gender disparity and access to health care. Considering close relationship of social economic status, caste and cultural practices, it is imperative to draw conclusions regarding gender disparity in health care access. Very few studies had evidence based on actual collected data. However, Most of the studies relied upon NFHS-3 or NSS data limiting the comparative analysis. Government sponsored insurance schemes like ESI (Employee state Insurance) or Community based Health Insurance schemes analysis might have added financial perspective to the achieve the objective.

V (b) CONCLUSIONS& RECOMMENDATIONS:

Even after 62 years of Independence, India is still struggling to provide adequate health services to all communities among different age groups. Low literacy, low participation in paid employment, poor access to assets, high out of pocket expenditure, unregulated private sector and poor health coverage among women who belong to poor families and communities, and these render them poorly equipped to deal with a multitude of deprivations. These deprivations are a reflection of unequal social and economic structures. In general, the gender inequality is persistent in every domain, and women are disempowered both absolutely and relative to men. Further, the progress toward gender equality and women's empowerment is also very slow. Considering wide interstate variations in cultural practices, different government programmes and enormous population, India has to plan universal health care very carefully. Innovative strategies to increase access which can be used to address the issues of health care access in Indian health system like community action to improve access to and use of pharmaceuticals; working with private and traditional providers to improve quality and reduce costs; enabling indigenous health systems and promoting an intercultural approach to health care. Encourage female literacy, providing more employment opportunities to women; create awareness about health among them will address demand factors which enables the improved utilisation of health care services.

Chapter VI

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