The Gender and Reproductive Health Research Initiative
Mapping a Decade of Reproductive Health Research in India

Gender Gaps in Research on Health Services in India

A Critical Review of Selected Studies (1990-2000)

Shelley Saha
TK Sundari Ravindran

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CONTENTS

I. CONTEXT

The responsibility of providing health care in India, a country of over a billion people, is shared by three major sectors - the public sector, the private sector and the household. The public sector is comprised of the central and state government, municipal and local bodies. The private sector consists of private physicians and a range of other practitioners (including those practicing non-allopathic systems of medicine), health facilities and corporate hospitals operating for profit, corporate bodies providing medical care to their employees, and non-governmental organizations (NGOs) operating as not-for-profit enterprises and providing services free of cost or at subsidised rates. Households provide a large proportion of first-level care in many settings, and this is especially true in a country like India where formal health services are unavailable or unaffordable to a significant section of the population.

In the public health sector health care is provided at three levels. Basic preventive care is provided through sub centres and Primary Health Centres (PHCs), which are also a source of curative care in a limited sense. At the secondary level, rural hospitals, community health centres and district hospitals act as the referral centre to the primary-level health centres. Tertiary health care is provided by specialist hospitals and teaching hospitals. Services are provided free of cost in most instances, although a fee may be charged for specific services such as laboratory tests or X-rays. To understand the organisation of public health services in India, it is important to note that in India's federal structure of governance, the states are responsible for 'health'. The central government may plan and fund health care services, but the responsibility for implementation rests with the state governments.

The rapidly growing private sector mainly provides curative services to those who can pay. The private sector is not organised but statutory bodies like the Indian Medical Association and the Medical Council of India regulate their activities, though to a limited extent. Traditional and indigenous systems of medicine also play an important role in meeting people's health needs.

In the first two Five - year plans of following India's independence in 1947 there appeared to be a commitment to addressing health needs of the populations comprehensively - with preventive, promotive and curative care provided through a wide network of community-based health centres, in tune with the recommendations of the well-known Bhore committee. But in the years that followed, the health sector appears to be driven by technological forces and become physician-centred, reducing the pursuit of health to the provision of medical care. The broader determinants of health have been ignored, and investments in providing basic amenities, for improving nutrition and living conditions, in better education and quality of life for the people have taken a back seat. Today a combination of forces is pressing for an even greater market orientation of health care. The country's economy is being further `liberalised' and dragged into the unequal, uncontrolled global market, leading to deterioration in living and working conditions for the majority, increased cost of medicines, corporatisation of medical care and medicalisation of women's life and bodily functions. Recently, the government has also introduced payment for services that would further hinder accessibility to health services. There is a steady withdrawal of state support for health services. But experiences from Latin America show that the state should continue as the main provider of health care since NGOs and the private sector cannot replace the state. The present paradigm of health care development has accentuated inequalities in health - between classes, age groups, and sex.

II. VIEWING HEALTH SERVICES RESEARCH IN INDIA THROUGH A GENDER LENS

Research on health services in India may be grouped under the following categories:

1. utilisation of health services, which is influenced by a range of factors including physical proximity and cost;
2. the quality of care provided; and
3. the organisation and delivery of health services including issues concerning health service providers.

In this paper, we examine studies carried out on health services in India over the past decade through a gender lens. Our intention is to synthesise from the body of research available, the ways in which gender in conjunction with caste and class influence the user, the provider and the organisation and delivery of health services, and to identify the range of issues that have not yet been adequately researched.

Viewing health service research through a gender lens would also mean being sensitive to how a bio-medical approach to health and illness as against a social determinants approach could lead to diagnostic and treatment procedures which reinforce gender and social stereotypes. For example, not seeing how repeated pregnancies may be a result of women's lack of autonomy and decision-making power and their subordinated status vis-à-vis men.

Wearing a gender lens would mean examining each aspect of health services to see if there are gender and social differentials that are avoidable and contribute to inequities in health between women and men and across social groups. This would include, for example, examining whether:

- the utilisation of health services is impaired by gender and social inequalities
- there are specific physical or financial barriers in access to health services which arise because of one's gender and/or social status
- men and women, and members of different social groups experience any form of overt or covert discrimination within the health services, either from service providers or because of the way services are organised
- the organisation of health services and allocation of resources points to a lower priority accorded to women as compared to men, the poor and marginalised as compared to the better-off groups in society; and
- whether and how gender and social stereotypes inform the way health providers at different levels are treated within the health sector, as well as how health providers in turn treat their clients.

The analysis is based on 132 studies conducted in India during the 1990s on various aspects of health services. These include select published studies and unpublished reports, which contain any data or information disaggregated by sex and/or social groups, or gender differentials.

The paper consists of three sections. The first section, of which this commentary is a part contains the background section stating the context and defining the scope of this paper. The second section synthesises research on utilisation of health services, quality of care, organisation and delivery of health services and health provider issues, and examines gender and social issues within each of these. The third section identifies priority issues that need to be addressed in research on the gender and social dimensions of the different aspects of health services in India.

III. WHAT DO WE KNOW?

Utilisation of Health Services, Costs and Choice of Providers

Services Used by Women and Men: A small number of studies, including two national surveys by the NCAER(1992) and the NSSO (1992,1998) examine both women's and men's utilisation of health services. These indicate that there is a gender difference in favour of men in the utilisation of health services for in-patient as well as out-patient care. Examples of indicators of utlisation used include proportion of illness episodes that are treated, or the proportion of hospital beds occupied by women as compared to men. There was one exception to this general trend, where a study covering five states reported no gender differences in utilisation (Chirmulay 1997).

Variations in utilisation across age groups and nature of problem within each gender is examined by one study from Nasik, Maharashtra, covering rural and urban areas (Madhiwala et al 2000). While the overall utilisation rates for health services is higher for males than for females, there were also variations across various groups of females. Female children (0-11 years) had a greater proportion of illness episodes treated as compared to girls and women above this age. Further, when compared with women suffering from other problems including reproductive health conditions, a greater proportion of women with fevers, respiratory problems and gastrointestinal illnesses tended to seek care - conditions which make them unable to carry on their daily tasks at home and outside. There was no such difference observable for men.

Another genre of studies (Duggal and Amin 1989; George and Nandraj 1993; Nandraj et al 1998; NCAER 1992; NSSO 1992 and 1998; Rajeshwari 1996; Ramamani 1995) seeks to identify factors associated with use or non-use of health services for an illness episode. These typically consist of a survey that collect data on a number of social and demographic variables as well as utilisation and do a multivariate analysis to identify factors 'significantly' associated, and come up with findings such as 'education' or ' type of housing' as significant variables. The studies of this type included in this review do find social differentials in utilisation of services but do not comment on gender differences, and more importantly, differentials between males and females across different social groups and whether and how these vary.

A few studies that have looked at health expenditure pattern (Madhiwala et al 2000; Nandraj et al 1998; NCAER 1992) show that more is spent per illness episode in men as compared to women, in all age groups or more number of men were treated as compared to women in the bottom expenditure groups. The exception is one study that reported that in the 0-1 and 25-44 age group, the expenditure on females was higher (George et al. 1994). The 52nd round of NSS indicates significant rural-urban differences in favour of urban areas, and within these gender differences as well. In rural areas the amounts spent per illness episode for outpatient care was Rs. 151 for males and Rs. 137 for females, while the corresponding figures for urban areas were Rs. 187 and Rs. 164. Differences were also found in the expenses incurred for inpatient care, not withstanding the fact that women have a greater need for inpatient services for childbirth (NSSO 1998).

In terms of determinants of expenditure on health for women and men, two studies found that as the size of the family increased, expenditure on health decreased, more for women than it did for men (Madhiwala et al 2000; Nandraj et al 1998). The second study reported that while in the case of women, more expenditure was incurred on medicines, more was spent on special diet for men (Nandraj et al 1998).

The NSS Round also found that the poor spent a considerably larger proportion of their income on health care as compared to the better off in both rural and in urban areas (NSSO 1992 and1998). This finding of higher burden of expenses for health care on the poor is corroborated by a number of other studies: the national survey by NCAER in 1994 (Ramani 1995), the state-level survey by Kerala Shastra Sahitya Parishad in Kerala in 1991 (Kannan et al 1991) and other micro-studies.

Apart from rates of utilisation and costs incurred, quite a number of studies (Chhabra et al 1990; Chirumalay 1997; Hitesh 1996; Madhiwala et al 2000; Nanda and Baru 1994; Nandraj et al 1998; Ramamani 1995) looked into gender and social differences in patterns of choice of health care provider. Overall, public sector health services are utilised more for inpatient care and for preventive services while private sector health services are used for outpatient care and curative services. As far as the economic status of patients are concerned, the findings are in the expected direction - that the poor tend to use public facilities more and the proportion using private facilities increases with increase in educational attainment, socio-economic status or with urban residence. One study (Nandraj et al. 1998) found that women were less likely to use 'formal' health services as compared to men, but it is not known whether this is an overall trend and whether choice of private versus public sector varies by gender across different types of health needs.

Reproductive Health Services: The vast majority of the studies that had any information on women's utilisation of health services dealt with reproductive health services, especially pregnancy and delivery care, and family planning. The overwhelming evidence in this regard relates to women's non-utilisation of health facilities for delivery, and low-utilisation of antenatal care. Reasons for non-use have either been probed through direct questioning of the respondents, or conjectured based on multivariate analysis. Several studies have indicated that women distrusted or disliked hospital delivery and preferred natural childbirth, and believed that antenatal care was not necessary.

In terms of use of referral facilities, a study from rural Rajasthan (Hitesh 1996) reports that a very large proportion of pregnant women referred to tertiary centres did not avail of the referral because of lack of money, transportation facilities or time, and those who did go were better-off and/or had their own means of transport. The interplay of gender and social status is borne out by this study, which shows further that when relatives were able to provide social support in terms of taking over the woman's domestic responsibilities, there was an even higher likelihood of a pregnant woman availing of referral even among the better off. Very similar findings are reflected in another study, also from Rajasthan (Unnithan-Kumar 1999), which found that work and lack of social support impeded access to health services. Further, the social and physical proximity of natal kinspersons had important implications for access to health care - human power, emotional support and financial support. This study also reported that delaying treatment till the acute stage led to a high cost of treatment per episode treated.

A study of women from a fishing community in southern Tamil Nadu (Ram 1994) examining why women did not use delivery services found that some of the reasons reported by the women included prolonged stay in hospital disrupting their gender-based domestic responsibilities, caste gap between provider and user, harsh treatment by delivery staff and unnecessary medical interventions. For women of this low-caste community, the harsh treatment they received in hospitals from higher-caste service providers seemed to suggest that high-caste intolerance of impurity, pollution and lack of learning was transposed into the idiom of hygiene, rationality and medical science.

Studies examining the association of various socio-economic factors with utilisation of services indirectly through statistical analysis (as opposed to direct questioning) find that women using antenatal

care were economically better-off than those not (Khandekar et al. 1993), had more years of education themselves as well as were married to men with more years of education (Khan et al. 1997), were non-working women and did not belong to the Scheduled Castes (Khandekar et al. 1993).

Interestingly, though, these associations are interpreted as implying the ignorance of women. The studies then argue for convincing and educating the illiterate women on the need for antenatal care and for trained attendance at birth, without probing for the ways in which socio-economic status may act as a barrier to utilisation of services. The conclusions drawn from the findings leap far beyond available hard evidence and in some sense, appear to reflect gender, social and medical biases in interpretation - that antenatal and delivery care is inherently 'good' for women irrespective of their quality, that anyone who does not see this 'truth' has to be ignorant and uninformed and needs to be educated and made aware.

In terms of choice of provider for reproductive health care, a preference for traditional *dais* (traditional birth attendants or TBAs) for delivery care is indicated by many studies. The low cost of services appears to be an important consideration. In the only study that actually documents cost of care, from Vellore in Tamil Nadu (Sahachowdhury 1998), the average expense incurred by a household for a delivery by the *dai* was reported to be Rs.25, an amount that would be inadequate even for getting a woman in labour to a health facility. This may be interpreted in two ways - as reflecting the inability of households to pay more, or the unwillingness to invest on childbirth, a reflection on the value placed on a life-and-death situation for women by their households and society at large. Cost was a consideration in choice of provider for induced abortion for one-third of the respondents, according to one study (Ganatra et al. 1998b). The same study also reported that women's heavy work load at home made them prefer abortion providers who did not insist on repeated visits or an overnight stay.

As for contraceptive services, the general pattern is to use public sector health facilities for contraceptive services, most probably because services are available free of cost. However, one study (Kambo et al. 1994) from Uttar Pradesh found that the involvement of traditional practitioners resulted in a significant increase in utilisation of contraceptive services, for both permanent and reversible methods of contraception. A tendency to utilise tertiary facilities for gynaecological problems and obstetric care, irrespective of the severity or seriousness of the problem is reported from a Maharashtra study (Chhabra and Saraf 1997).

The sequence of care seeking was examined in one study (Sood et al. 1994) covering rural Haryana. Home treatment in the initial stages followed by government facilities seemed to be the strategy of the poor, who ultimately seem to have reached a private practitioner. The better off went straight to the private practitioner.

Research Gaps: Many areas remain unexplored, some of which have been indicated above. In terms of gender and differences in utilisation of services, while differences have been noted by many studies, few probe deeper into the reasons why. Is it because of gender differences in access to resources, or because women do not feel entitled to use health services unless the condition is very serious, or because they do indeed suffer from conditions that are less serious than those suffered by men? Similarly, why are the costs per episode different for women and men? This could be because women seek care earlier and therefore have a shorter duration of treatment as compared to men, or because they seek care from providers who charge less, or because they do not complete treatment because of cost considerations.

Other concerns about the utilisation of health services about which little is known are: gender and social differences in the delay between onset of symptoms and care seeking, in the sequence of providers and facilities used and the appropriateness and adequacy of these in relation to the problem experienced. For example, studies from some countries have shown that women seek first level care from traditional practitioners or from those located closer to home while men tend to go to a specialist facility right away. There is also little known about gender differences in treatment compliance or the outcome of treatment.

In terms of utilisation of reproductive health services by women, studies are needed that go beyond victim blaming and seek to understand the barriers that make it difficult for women to receive adequate, appropriate or timely care. Overall, studies documenting the process of decision-making and the considerations that play a role in deciding whether, where and when to seek care are urgently needed, and these need to examine how these considerations vary across social groups and by gender.

Quality of Care

The concern with quality of care has been historically related to the provision of family planning services, rather than health services as a whole, and the studies reviewed here reflect this (Bahl and Trakroo 1996; Foo 1995; Gangopadhyay and Das 1997; ICMR 1991; Levine et al 1992; Narayana 1995; Reddy undated). All the studies on the quality of care in family planning programmes agree that the quality of care falls below acceptable levels in many respects - from physical infrastructure and availability of personnel, basic hygiene, equipment and drugs to technical skills of personnel, the quality of client-provider interaction and respect for the client's privacy and autonomy. Notable among these is a study from Kerala (Ramanathan et al. 1995) providing a graphic description of conditions in a laparoscopic sterilisation camp which gives the reader a peep into the horrific conditions that women accepting sterilisation have to contend with, and the unfortunate lack of any concern for maintaining even basic acceptable standard of safety and hygiene on the part of service providers. Coming from a state like Kerala which is known for high levels of female literacy and widespread availability and use of contraceptive services, this study makes one wonder what the worst case scenario from a less socially developed setting would be. An extensive review of studies on quality of care in family planning (Foo 1995) confirms that the quality of care in sterilisation services is indeed poor. The provider-client interactions during sterilization camps demonstrated that empathy with women was entirely absent. The modesty of women patients was nowhere respected with the lack of spatial privacy at these camps.

In the case of abortion services, the issue is not only poor quality but also limited access. The mismatch between trained personnel and availability of essential equipment for MTP, poor quality of training of service providers is remarked by some studies (Bahl et al 1996), while other have highlighted the disregard for the woman's autonomy by requiring the signature of their husbands on the consent form before abortion is provided, and insisting on the acceptance of contraception following abortion. Also, the way women were treated by abortion providers changed according to the social and economic status of the women. Unmarried women had less bargaining power within the public sector health facilities and were forced to seek abortion from unregulated private services (Gupte et al. 1995).

Admittedly, most of these studies reflect the situation that existed before the introduction of the Target Free Approach (TFA) in the family planning programme. Hence, an important question for assessment is whether there have been major changes in quality of care subsequently? It would appear not, as reported by a 1999 study covering 9 states in India which focused specifically on the changes following the introduction of the Target Free Approach and the replacement of centrally determined target with a Community Needs Assessment (CNA) approach (Health Watch Trust 1999). While changes were noted in terms of knowledge of service providers, and in some states, an expansion of the range of services provided, the study found no visible improvement in the quality of care in family planning services.

Delivery Care: There are very few studies on the quality of delivery care in hospitals or at home. A rare study on hospital-based delivery care is from Vellore in Tamil Nadu on the information given to mothers in the labour-room by nurses, doctors, ANMs and students (Celcy 1998). The study found that more information was provided on second stage labour than any other phase, and nothing at all about examination per vaginum, catheterisation and instrumentation. Demographic variables were not significantly associated with the amount of information given. The focus on the second stage was related more to the anxiety of the attending personnel and their interest in getting this stage over as soon as possible.

The quality of delivery care provided by *dais* has been addressed in three studies - one from Delhi (Sharma et al. 1990), another from Vellore, Tamil Nadu (Sahachowdhury 1998) and a third from rural Bihar (Chattopadhay 1996). The Delhi study reported that despite women's overwhelming preference for TBAs for conducting the deliveries, the services left much to be desired in terms of hygiene, and the *dais*' ability to recognise danger signals was unsatisfactory. The Vellore study and the Bihar study also remarked on the poor, unhygienic and unsafe nature of delivery care provided and recommended a system of monitoring quality of care in deliveries conducted by TBAs. The reason why women prefer services provided by *dais* becomes clear from the Delhi study. The *dais* help women with their household chores, and available when needed, are kind and considerate, and last but not the least, charge an extremely low fee for their services.

Two studies (Levine et al. 1992;Subrahmanyam 1997) concern themselves with quality of care in general health services in the public sector. These studies confirm the findings of studies on determinants of choice of provider discussed in the section on utilisation above, that there is general dissatisfaction with pubic sector health services. Community members from Uttar Pradesh who were asked about their satisfaction with PHC services reported that communication between health staff and the community was the most problematic. Many respondents were dissatisfied but feared penalization if they complained. Free and better medicines, better attention from personnel and ambulance service for emergency were requested by the respondents. The second study which concerned itself with quality of services in a rural government hospital in Andhra Pradesh found violence of client's rights by rampant corruption, unhygienic environment, negligence of patient safety and well-being by health personnel.

The Private Sector: Considering that the private sector accounts for the majority share in the provision of health services, studies that have analysed the quality of care in this sector are few and far between, except for those looking at delivery services by *dais*. The two studies included in this review on quality of services provided by the private sector approach this from two different angles. One study evaluates the physical standards of private health facilities in two *talukas* of Maharashtra, based on certain objective standards, and finds that the private sector facilities fall short of standards in most instances (Nandraj et al. 1996). The other study reflects the perspective of users on the differences between the public and private sector health services in the quality of care provided (Levine et al. 1992). This latter study from rural Uttar Pradesh documented patients' rating of services on the following aspects: effectiveness of treatment, thoroughness of examination, care by a doctor (as opposed to paramedic), waiting time, timing of opening and closing, provision of medication, provider-patient communication and doctors' qualifications. Users gave a higher rating to the private sector on all except for doctor's qualifications and experience and cost.

Users' Perspectives: Users' perspectives on quality of care is presented in only one study, which is rich in women's insights on this issue (Gupte et al. 1995). This study from rural Maharashtra emphasises that what women wanted from services depended on the kind of health need that they are seeking help

for. For general health needs, they want what anyone - man or woman - would want. This included easy access, and availability of a doctor for handling emergencies at any time. Cleanliness was another important dimension of quality as expressed by the women. Provider attitudes of empathy and concern and provision of counselling were rated as very high. For reproductive health needs, and specifically for abortion, confidentiality rated above all else and was followed by a respect for women's autonomy to choose an abortion: by not requiring that her husband sign his consent for her abortion nor that she accept a method of contraception immediately following the abortion.

Research Gaps: While the Gupte et al. (1995) study is an excellent example of one with a women-centred approach to quality of care, none of the above studies - whether of quality of care in reproductive or general health services, or the public or private sector, examine how the definition and yardsticks with regard to quality of care varies across different social groups, or between women and men.

There are also very few studies looking at the issue of whether women and men of different social groups receive differential reception and quality of health care from service providers at different levels, and the nature of these differences. Studies also need to go one step farther and examine whether and how these differences in quality of care as perceived by researchers and/or the users actually impact on utilisation of services for different health needs. This is especially important for reproductive health services where the non-utilisation of services by women is a major issue. There is a large gap in terms of qualitative studies across different settings and social groups that look at what actually happens or document what women and men have to say about their expectations about quality of care for reproductive health needs.

In pointing out these gaps, it must be noted here that there are a number of articles covered by this review that are more in the nature of commentaries rather than studies, on gender differentials in experiences with the health care system. One study, for example, points out that women have been unable to articulate their discomfort within the framework of an establishment that has been unreasonable and expected them to: (a) rest at will; (b) visit an out-patient clinic between 8.30 and 9.00 a.m. (after cooking, washing, bathing, and other household chores); (c) return for regular follow-ups when the household demands on her services always take priority; and (d) accept that many drug side effects as normal (Shatrugna 1994).

The Structure, Organisation and Management of Health Services

The studies included in this category examine varied issues, ranging from larger issues of resource allocation and manpower deployment in different states, the relative importance of the public and private sectors in health care, and trends over time, to the training, skills and job satisfaction of service providers. Studies on health providers have exclusively focused on those at the lower levels of the hierarchy within the formal and informal system (Benara and Chaturvedi 1990; Roy Chowdhury 1990; Sahachowdhury 1998; Sharma et al 1990; Shrorti and Bhatlavande 1994) - the ANMs and the traditional birth attendants or *dais* and unqualified rural practitioners, not physicians or specialists.

The broad picture that emerges from these studies is as follows. Resources availability for the public health sector show a declining trend as a result of declining share of allocations by the central government and the resource crunch within states. The share of central grants in state health expenditure declined from 27.9 per cent in 1984-85 to 17.2 per cent in 1992-93, for diseases programme from 41.5 to 18.5 inspite of an increase in morbidity and mortality, and overall from 19.9 per cent during 1979-82 to 3.3 per cent in 1992-93. Though state's share in health spending has increased from 71.6 per cent in 1974-82 to 85.7 per cent in 1992-93, it is not commensurate with the health needs of the

people. Given the dependence of the poor on public health facilities for serious health problems needing in-patient care and for preventive care, it may be anticipated that this trend will lead to a worsening of inequalities in health within and across states (Duggal et al. 1995). Those states with the least resources will have, on the one hand, a higher burden of disease, and on the other, less resources for providing health services to those most in need.

The reduction in allocation of resources is not as much the result of economic constraints as it is of a deliberate shift in policy to reduce the role of the state in the actual provision of health services and make its function an essentially regulatory one, with some responsibility for providing essential preventive and curative care to those most in need. While several studies have commented on the likely consequence of this trend for health inequalities, very few provide hard evidence showing a worsening of health indicators when compared to a baseline. One study (Bennett and Muraleedharan 2000), however, documents the nature of changes attempted by one state - Tamil Nadu - in an effort to make public sector services more efficient and cost-effective. New public management techniques are being tried out in the public health sector, mainly to increase efficiency and optimise costs - including contracting out certain services. But this process has been hampered by the weight of bureaucratic procedures, for example, the delays in making payments for services rendered has meant that there are few takers for contracts offered by the government. The state's effort to act as a regulatory body, through the enactment of the Private Clinical Establishments Act has been thwarted by the power of the medical profession, which does not wish to see itself regulated by any non-professional body. Yet another initiative that has met with moderate success, is the setting up of autonomous bodies, which take on some of the functions of the Department of Health - e.g. Tamil Nadu Blindness Control Society and the State AIDS Control Society. They receive their finances from the government or international donors, and are financially more flexible and able to implement policies faster. However, the informants interviewed for this study emphasised that good leadership and lack of political interference alone could ensure this. Flexible and result oriented staff policy was another important factor.

Increasing Emphasis on Private Health Care: Simultaneous to the diminishing role of the state in the provision of health services, there has been a steady rise in the share of the private sector. The entry of industrial houses into the health care sector in south India, where multi-speciality hospitals based on the American model, cater to the middle and upper classes, is one manifestation of this trend (Baru 1994). These for-profit corporate enterprises are reported by one study of Madras hospitals (Sukanya 1996) to invest 20 times more on medical equipment when compared even to other private sector facilities, and it would not be unfair to suggest that the likely consequence of this would be avoidable and wasteful expenditure on unnecessary tests and procedures, given that these hospitals work on the basis of returns to investment.

The nature and quality of private sector facilities that emerge to meet the unmet demand for health care caused by reduction of investment in the public sector health facilities would depend on the paying capacity of the population. Thus, both public and private sector facilities would favour the more economically advanced regions of the country than the poorer ones. This is illustrated by a study from Andhra Pradesh (Baru 1993) on inter-regional variations in health infrastructure within the state. Large variations between backward and advanced districts was found in the number of sub-centres and PHCs, and for nurses and paramedical staff per 1000 people but not for doctor/population as far as the public sector was concerned. This implies that the poorer districts would have fewer functioning sub centres and PHCs and therefore poorer access to health care than better-off districts, and that this would affect the poorer sections of the population in the poor districts far more. Inequalities in health would widen dramatically between the poor in the poorer districts and the better off in the advanced districts. Private sector facilities, for reasons of paying capacity as discussed above, were also concentrated in the more economically advanced districts. What is interesting about this study is the finding that the gaps in

health services provided by the public and private-for-profit sector was not filled by the voluntary, or private, not-for-profit sector. Rather, they were also serving the relatively better-off geographic regions that had pucca roads, communication facilities and electricity, and many were located in and around the capital city so that staff could station themselves within the city.

Yet another study focusing on inequalities (Rao 1998) discussed the inability of the existing health system to meet the needs of the marginalized tribal population in Andhra Pradesh, which experienced high rates of maternal and under-five mortality and nutritional deficiencies. The study advocates for a 'social determinants' approach to the planning of interventions for this population, which would provide comprehensive health care while addressing the root causes of illnesses - poverty, landlessness and powerlessness.

The dearth of information available about the private sector that accounts for a majority share of health care provision is highlighted by one study from Maharashtra (Jesani et al. 1993). This study also discusses another dimension in the nature of inequitable distribution of health care services - between rural and urban areas, and also between curative and preventive care, with the former dominating. Lack of regulation of the private sector is a major issue, because the irrational practices of this sector affect a greater proportion of the population. But the more important reason for ensuring ethical and standard practices in the private sector is because this sector enjoys the privilege of setting the norms and the value systems of medical practice in the country.

Have the changes in the health sector described above had differential impact on the access to and utilisation of health care by women and men across different social groups? What has been the nature of these differences? What have been the health consequences of these, and once again, do they impact differentially on the health outcomes of different social groups, and on women and men? These are only some of the many questions that are yet to be addressed by health service research in India.

It is against this backdrop of increasing privatisation and corporatisation of health services and diminishing investments by the government sector that new challenges were posed to the health sector by the ICPD Plan of Action's call for reproductive health services. The provision of comprehensive reproductive health services that are affordable and high quality clearly needs the injection of substantial resources, financial, technical and human, into the health sector, and a major overhaul of it functioning, moving from a top-down population control approach to a community needs based approach.

But for a lone study (Heath Watch Trust 1999), which assessed the progress of the CNA approach to contraceptive services in nine Indian states, there is a major gap in information on this crucial area. This study concluded that there were some changes from centralised target setting to more locally determined targets, but contraceptive choices were still made by service providers on the basis of the number of children women had, and not by women themselves. There was no improvement in terms of access to and availability of MTP services, and in the best of scenarios, reproductive health services translated into sporadic camps screening for and treating RTIs and STIs. A couple of other studies comment mainly on the gaps -such as the neglect of adolescent sexual and reproductive heath needs, and the lack of integration of services for HIV/AIDS and maternal and child health and family planning (Jejeebhoy 1996; Pachauri 1994).

India is a country rich in the non-governmental sector, with a widespread network of actors across different regions in the country, and experimentation with innovative approaches. Their experiences have been documented in reports and in grey literature, but have rarely been published in mainstream journals, and even more rarely do they provide data on how their approach impacts on health outcomes. Two studies included in this review describe alternative approaches, one by a rural women's

organisation in Tamil Nadu (Sokhi 1998) another by a more broad-based community health organisation (Khale et al. 1991). This latter study from Maharashtra documents the impact of a comprehensive approach to MCH which was community as well as health- facility based, human-power intensive, integrated the traditional birth attendant into the health care delivery system and mobilises local women to both seek informed care and to maintain accountability. The whole intervention was characterised by effective planning and management. The neonatal mortality declined from 94.8 in 1978 to 39.1 per 1000 in 1988, and maternal mortality showed a consistent downward trend.

Providers: We now examine the small number of studies that deal with issues concerning health service providers. Given the limited human resources in the health sector and the wide gap in meeting people's health needs through the formal health sector, it would seem important to better understand the nature and quality of health resources widely used by the poor and the marginalised in order to improve these. Only one of these is about providers of general curative services. This study (Rohde et al. 1994) from rural Uttar Pradesh which interviewed 'doctors' identified by mothers with young children found the vast majority to be unqualified to practice allopathic medicine but doing so. The study argues for training and integrating these providers into the health care system, given their accessibility to users and their interest in improving their knowledge and skill-base.

Studies on health provider issues also highlight the gaps in reproductive health services, especially in term of trained attendance at delivery. It is to the humble rural *dai* and the auxiliary nurse midwife that the task of meeting the reproductive health needs of the majority of Indian women falls. What do we know about who they are, what they do and what their training and other needs are? One study (Chattopadhay 1996) from South Bihar expresses concern over the deterioration of the status of the *dais* who belonged to a lower caste and were already poor, because of the prejudices of the formal medical system, and suggests training and integrating them into the formal system.

Training of the *dais* or TBAs has been part of the government's strategy to improve the quality of delivery care available to Indian women, and to prevent maternal and perinatal mortality and morbidity. Thousands of *dais* have been trained over the past decades and left to their own devices following a single training encounter, to effectively carry out this task. A 1994 published study from rural Maharashtra (Shrotri et al. 1994) followed up 1420 *dais* who had undergone *dais* training, and found that about 62 per cent were functioning as birth attendants, but were providing only delivery care and not antenatal or postnatal care. They were not integrated into the formal health care system, and received little remuneration and no supervision or referral back up.

The TBAs are not equipped to deal with emergencies, but do not have the back-up support to refer complications, such as ambulance services. The ANMs who have been solely concerned with targets for population control have lost their midwifery skills. There is an urgent need for skilled midwives who can provide community-based delivery services, but this cadre is all but absent (Bose et al. 1998). It seems like a tall order to be talking of reproductive health services when even the basics in terms of trained attendance at delivery and referral for complications in not available to the majority of Indian women.

While a number of studies examined in earlier sections have shown that women preferred to use TBAs for delivery while others have expressed concern over the quality of care provided by them, no study covered by this review has dealt with what this group of providers have to say about their work and their needs. We have no data on the levels of support (or absence of it) they receive from the formal sector, their experiences in encounters with physicians and specialists in hospitals when they accompany women in labour in an emergency situation, and their own suggestions and perspectives on how they could play a better and more effective role.

Studies have addressed diverse issues concerning ANMs and other nursing cadre engaged in the provision of reproductive health care. The training provided to these categories of personnel falls short of equipping them with the skills necessary for independent management of cases, and this is compounded by an absence of standard setting for quality of nursing care (Gulani 1998; Sridhar 1998). Their working conditions leave a lot to be desired (Mishra 1997). Frequent transfers, heavy work-load compounded by the backlog of vacant posts lying unfilled, having to stay in remote villages which hinder their children's education and threaten their security, and lack of transport facilities are all problems faced by them.

The gender and social dimensions of the issues and problems faced by ANMs is pointed out by a few studies (Health Watch Trust 1999; Iyer et al 1995; Ramachandran and Visaria 1997), but has been the central focus of only one study in our review. This study interviewed ANMs from rural districts of Maharashtra (Iyer et al 1995) and observed that ANMs faced professional and administrative subordination to doctors and nurses. Their modest class background and their gender status as females in a patriarchal society, their youth and status as outsiders in the community in which they are supposed to work, all interacted to compound their powerlessness. Trying to achieve a delicate balance between their role as family planning motivators as required by the state, and health care providers, as demanded by the people, in a context of grossly inadequate facilities, poor training, lack of equipment and infrastructure, affected their relationship with the community. Their personal lives were affected as a consequence of the stigma and low value accorded to the nurse/midwife's occupation, which had ramifications for their marriage prospects and familial relationships.

In case studies from Karnataka, ANMs reported that their work was tightly supervised whereas their male counterparts were rarely made accountable or evaluated (Health Watch Trust 1999). Again, male multipurpose workers had a higher status in the health delivery system and were seen as 'doctors', while ANMs were treated as mere birth attendants although they bear the entire burden of grass roots implementation of family planning services, child survival and safe motherhood initiatives (Ramachandran and Visaria 1997).

These studies draw attention to the fact that while lady health volunteers (LHVs) and ANMs are the most vital link in the entire chain of health care delivery system, their issues receive little attention. How could one expect the reproductive and child health programme to function effectively, when programme planners and policy makers are not addressing these issues? The RCH programme now expects them to be more technically efficient, provide better quality of care and be gender-sensitive (Prakasamma 1998), which appears to be more in the nature of wishful thinking than realistic planning and programming.

Research Gaps: As mentioned earlier, there appears to be an absence of research on other categories of health serviceproviders, both in the public and private sectors - especially physicians and specialists who provide reproductive health services. What is the caste/class and sex distribution of these categories of health service providers? Do they experience differential treatment and/or discrimination within the health sector because of their social or gender status? Do they have equal opportunities for training, career advancement and occupying decision-making positions?

The attitudes of health service providers and their impact on reinforcing or weakening gender and social stereotypes is another major area that has not been adequately covered by studies having service providers as respondents (provider attitudes are usually reported in user perspective studies), and this is equally true for *dais*, ANMs and rural practitioners as it is for doctors and specialists. Further, it would be important to understand how these attitudes impact on the nature of services they provide and the decisions they make regarding diagnosis and treatment, and ultimately, to the health of the women and

men they serve. This is especially important in the area of reproductive health care, where there is a lot of anecdotal as well as user-reported evidence on the harsh and prejudiced attitudes of obstetrician/gynaecologists towards poor women in labour, and those seeking abortion and contraception or care for sexually transmitted infections (STI).

IV. OUTSTANDING RESEARCH NEEDS

The above review suggests that much of the research on health services in India is narrowly focused on the public sector and on the provision of family planning services, and limited in scope in term of getting to the depth of issues or providing insights into the processes which cause low utilisation, poor quality of care and limitations in the organisation and management of services. In terms of contributing to an understanding of how gender and social status influence these various dimensions of health care services, the gaps in our knowledge are substantial, and we may have barely scratched the surface in our grasp of these issues. Key areas of research warranting further attention are summarized below:

1. The studies reviewed here bring into light the gender and social factors that contribute to differential utilization of health services at different levels, health care seeking behaviour, in treatment compliance and in outcome of treatment. In terms of utilisation of reproductive health services by women, studies are needed that go beyond victim blaming and seek to understand the barriers that make it difficult for women to receive adequate, appropriate and timely care.

2. Studies need to examine whether and how the definition and yardsticks with regard to quality of care varies across different social groups, and between women and men. And, further, whether these yardsticks vary for the same group for general versus reproductive health services, for public versus the private sector and for serious and life-threatening conditions versus common health problems.

3. Studies also need to go one step farther and examine whether and how these differences in quality of care as perceived by researchers and/or the users actually impacts on utilisation of services for different health needs. This is especially important for reproductive health services where the non-utilisation of services by women is a major issue.

4. In terms of areas and sectors on which more work is needed on quality of care, the following may be identified: antenatal and delivery care as well as general health services provided by public and private sectors at different levels (and not only the *dais* and ANMs); and family planning services provided by the private sector, especially 'lady' doctors consulted by millions of women across varying class backgrounds.

5. The impact on the access to and utilisation of health care by women and men across different social groups, following changes in the health sector since the introduction of economic reforms in India, is an area of priority. While anecdotal evidence suggests deterioration of access for the poor, we do not have hard data on this, or on whether the impact has been different for women and men. More importantly, we need to know what the health consequences are, of any changes in access and utilisation, and whether they impact differentially on the health outcomes of different social groups and on women and men.

6. A very large research gap concerns the impact of health sector reforms, specifically on reproductive health services not only in the public but also in the private for-profit and non-profit sectors, and the consequences these changes for the reproductive health and well being of women and men. More case studies of alternative and innovative approaches to organisation and management of health services that are gender-sensitive are needed which can also document the impact of these approaches on health outcomes.

7. No study covered by this review has dealt with *dais*' perspectives on their work and their needs, the support (or absence of it) they receive from the formal sector, their experiences in encounters with physicians and specialists in hospitals when they accompany women in labour in an emergency situation, and their own suggestions and perspectives on how they could play a better and more effective role.

8. There appears to be an absence of research on physicians and specialists who provide general and reproductive health services. What is the caste/class and sex distribution of these categories of health service providers? Do they experience differential treatment and /or discrimination within the health sector because of their social or gender status? Do they have equal opportunities for training, career advancement and occupying decision-making positions?

9. It is important to understand how gender and social biases of service providers impact on the nature of services they provide and the decisions they make regarding diagnosis and treatment and, ultimately, to the health of the women and men they serve. This is especially important in the area of reproductive health care, where there is a lot of anecdotal evidence on the harsh and prejudiced attitudes of ob/gyns towards poor women in labour, and those seeking abortion and contraception or care for STIs.

In conclusion, if health services are to become receptive to the needs of users and effectively reduce the enormous burden of avoidable mortality and morbidity that the people of India experience despite the availability of medical technology and expertise, then conscious efforts needs to be taken to build the ability of society and health providers to identify and address issues of gender and social equity in health services. The first step in this long-term endeavour would be to carry out meaningful research that is informed by a gender and social perspective. We hope that this critical review has contributed to this first step by identifying the long list of unexplored issues in this regard.

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