Experiences of women while availing services in the Private Healthcare System of India

Executive Summary

With 66% of India's population receiving treatment from a private hospital or clinic, this paper looks at the experience of women in this sector. The out of pocket healthcare expenditure for the treatment of reproductive health-related diseases in private facilities is 5.4 times higher than in public health; Around 75% of women delivering in private institutions in Gujarat experienced catastrophic health expenditure. While health insurance is expected to address out of pocket expenditure on healthcare, research on public health insurance does not do justice to women's health needs. Almost two-thirds of all non-childbirth spending was on males under Rajasthan's health insurance scheme. Higher out of pocket costs of healthcare disproportionately deter female utilization, especially among elderly patients. The female share of spending in the AP health insurance program was only 39%. As research from TN shows, complex processes of claiming insurance coverage are stacked against women. The absence of adequate regulation of costs and perverse incentives created by insurance schemes encourages unnecessary medical procedures like caesarean sections and hysterectomies. Despite the higher charges in private hospitals, they often lack basic standards of care. Segmenting the healthcare sector into a system where public hospitals are the site of care for the poor while private healthcare is the aspiration for those that can pay converts health from a right to a commodity. The paper makes recommendations for both strengthening equity, accountability and regulation of the private health sector and addressing the specific challenges faced by women.

Introduction

In India's patriarchal[1] society unequal gender power relations precipitate ill-health for women. It has been estimated that 63 million women are statistically "missing" across India in the face of sex selection and poor nutrition and medical care.[2]

Globally[3] about 800 women die every day of preventable causes related to pregnancy and childbirth; 20% of them are from India. Women are found to have higher rates of morbidity[4] and hospitalization. Health-care expenditure on women in India is systematically lower than on males across all demographic and socio-economic groups[5]. In a study in Tamil Nadu, women were found to have lower shares of hospitalizations (42 %), bed-days (45 %) and hospital costs (39 %) for sex-neutral conditions; the disparity was observed across 14 of 18 disease categories and in all age groups, especially for the oldest and youngest women.[6] Women are also more discriminated against when health care has to be paid for by borrowing, sale of assets, or contributions from friends and relatives (distressed financing)[7]. Compared to non-poor men, the poorest women were five times more likely to never seek treatment[8]. Women from Dalit, Adivasi and other marginalized communities suffer from greater neglect and hence experience lower health outcomes. Disrespect and abuse during labour and

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[1] http://www.mfcindia.org/main/bgpapers/bgpapers2014/am/bgpap2014zh.pdf
[2] https://www.theguardian.com/world/2018/jan/30/more-than-63-million-women-missing-in-india-statistics-show
[3] https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3013263/
[5] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0158332
[6] https://gh.bmj.com/content/3/3/e000859
[7] https://www.sciencedirect.com/science/article/pii/S2352827318302787
[8] https://pubmed.ncbi.nlm.nih.gov/21741737/

delivery are rampant, with one study finding that 22.4% of women experienced mistreatment during delivery[9].

The neglect of women's health must be seen in the context of an unequal and underfunded public health system where basic standards of care are often not met in the public health system. India spends only 1.3% of its Domestic Product (GDP)[10] on healthcare compared to a policy benchmark of 2.5% and 6% global[11] spending average. Private hospitals now account for 55% of in-patient cases.[12] Taking in-patient and outpatient care together, about 66% of India's population gets treatment from a private hospital or clinic[13]. The weak, and sometimes absent public health infrastructure forces women to resort to the for-profit private sector, leaving them vulnerable to exploitation given the weak regulatory frameworks for private hospitals in India. The most frequent reasons for not seeking care from the public sector include low quality of care (48%), long waiting times (46%) and absence of nearby facilities (reported by 40% of households)[14].

This brief provides an overview of women's experiences in the private health sector in India. An overview of the public health system from a gender lens and suggestions for the strengthening of the public system, while essential, are outside the purview of this paper. It was written to consolidate the evidence on women's experience in the private healthcare system to support advocacy among grassroots groups, networks and activists working on women's health.

Financial burden faced by women in private hospitals

The cost of treatment in private hospitals in India is unaffordable for poor households. In a study in Gujarat, around 75% of women delivering in private institutions had a health expenditure of more than 10% of total annual family income which amounts to catastrophic health expenditure.[15] The out of pocket healthcare expenditure for the treatment of reproductive health-related diseases in private facilities is 5.4 times higher than in public health facilities[16]. For private hospitals across India[17], the mean inpatient medical expenditure was Rs 12,429 for reproductive health-related diseases. At the OPD level, the mean surgeon fees for their treatment in private facilities were Rs. 4384, compared to Rs. 120 in public facilities. The mean medical costs for treatment in private and public facilities for reproductive health-related diseases were Rs. 3467 and Rs. 870 respectively.[18]
Similarly, patients with tuberculosis who attend private hospitals spent three times more on hospitalization and twice more on outpatient care compared to those who attend public hospitals. The Out of Pocket expenditure for women patients during each episode of hospitalization (Rs. 13136) was lower than for men (Rs. 15297), but OPD costs were higher for women (Rs. 900 vs 691).[19]

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[9] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-1970-3
[10] https://factly.in/data-what-is-the-public-health-expenditure-in-india-as-a-share-of-gdp/
[11] https://apps.who.int/nha/database/DocumentationCentre/GetFile/58717341/en
[12] https://indianexpress.com/article/business/private-hospitals-account-for-55-of-in-patient-cases-public-hospitals-42-6134065/
[13] https://www.livemint.com/news/india/less-than-a-third-of-indians-go-to-public-hospitals-for-treatment-11588578426388.html
[14] http://rchiips.org/nfhs/NFHS-5Reports/NFHS-5_INDIA_REPORT.pdf
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6166517/
[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5945049/
[17] https://www.researchgate.net/publication/325076384_Triple_burden_of_disease_and_out_of_pocket_healthcare_expenditure_of_women_in_India
[18] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06777-7
[19] https://www.researchgate.net/publication/331578844_Out_of_pocket_expenditure_on_tuberculosis_in_India_Do_households_face_hardship_financing

These costs must be considered in the backdrop of the fact that in India, households spend 37% and 20% more on men's health in private healthcare in rural and urban areas respectively.[20] This places women's health at particular risk. Thus, leaving the emergency department without treatment or against medical advice is associated with poorer health outcomes, including an increased risk of mortality in a private hospital in India. A study looking at emergency admissions in a private hospital in India in 2010 found that women were more likely to leave the Emergency Department against medical advice for financial reasons; in not a single case in the study was the decision to do so made by the woman patient herself.[21] In almost all instances, it was the private hospital's expectation of advanced payment which acted as the barrier to obtaining care.

At the same time, research from Karnataka suggests that even non-poor women are substantially less to private hospitals run by qualified doctors than poor (6.3% versus 12.6%) or even the poorest men (23.3%); instead, they were more likely to consult private 'doctors', many unqualified, who practised outside of hospitals than both poor men and the poorest men (52.3% versus 33.9% poor and 30.2% poorest men respectively)[22].

Gender blind insurance schemes fail to address the challenges of women

Health insurance is expected to address out of pocket expenditure on healthcare. According to information shared with Parliament, about 498.7 million people in India had health insurance coverage in the financial year 2019-20 which amounts to only about 37% of the population[23]. Only 30% of women and 33% of men aged 15-49 are covered by health insurance or a health scheme, even If the coverage rate has been rising[24]. There are challenges with identifying poor families, and the verification of eligibility[25]. Furthermore, most health insurance does not cover outpatient consultations, the cost of drugs, and attendant and transportation costs, which formed a major proportion of health expenditures imposing a considerable financial burden on households. In this context, it would be critical to examine the extent to which existing schemes are able to serve the interests of India's women.

A study of Rajasthan's health insurance scheme Bhamashah Swasthya Bima Yojana found that almost two-thirds of all non-childbirth spending was on males[26]. Indeed, the women's share of utilization has been decreasing over time, from 47% in 2016 to 44% in 2019, even as overall utilization of the scheme had increased sharply over the same period. Similarly, for Andhra Pradesh's health insurance program, the women's share of hospitalizations for "sex-neutral" conditions between 2008 and 2012 2012 was only 42%; the female share of spending on this program was an even lower 39%.[27] In contrast, just under 45% of healthcare spending is on men in the Netherlands, Korea, and the Czech Republic[28].

Higher out of pocket costs of healthcare disproportionately deter woman's utilization, especially among elderly patients. In the earlier quoted study in Rajasthan, the female share of healthcare visits decreases by 1.32% with every 1,000 INR increase in the average charge. Furthermore, the female share decreased by 1.5% with every additional 10 kilometres that a household must travel to reach

[20] https://www.indiaspend.com/gendercheck/insurance-women-access-to-healthcare-rajasthan-government-bhamashah-health-insurance-programme-759516
[21] https://link.springer.com/article/10.1186/1865-1380-7-13
[22] https://pubmed.ncbi.nlm.nih.gov/21741737/
[23] http://164.100.24.220/loksabhaquestions/annex/175/AU3003.pdf
[24] http://rchiips.org/nfhs/NFHS-5Reports/NFHS-5_INDIA_REPORT.pdf
[25] https://thewire.in/health/nhps-may-create-more-roadblocks-than-easier-access-to-healthcare-for-poor
[26] https://www.nber.org/system/files/working_papers/w28972/w28972.pdf
[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6035505/
[28] https://www.oecd.org/ health/Expenditure-by-disease-age-and-gender-FOCUS-April2016.pdf

the nearest hospital because the cost of travel is higher for women.[29] This is triggered by safety concerns, the lack of financial autonomy and reduced freedom for mobility. At the same time, only 52% of the respondents in the NFHS V survey reported that women had freedom of movement to visit a health facility and 50% to places outside the village/community[30]. Women, especially in poor households, also resort to "rationing healthcare" by altering health-seeking behaviour, seeking less treatment or delaying treatment, with adverse health consequences ranging from recurring or prolonged morbidity to untimely death[31].

Other elements of design also hurt women. Thus, the fact that the erstwhile Rashtriya Swasthya Bima Yojana national insurance programme allowed enrolment of only five members of a household meant that households which had more than five members were less likely to enrol daughters[32]. Research from TN, furthermore, suggests that women found it more difficult to navigate the complex processes involved in enrolling, often lacked documents necessary for enrolment and subsequently utilizing the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS)[33]. High-end procedures accounted for 52.4% of claims under the same and the scheme as a whole was skewed towards low probability and high-cost illness events and SRH services were excluded.[34]

Greater use of healthcare by women for sex-specific conditions, especially those related to childbirth may mask the true extent of unmet healthcare needs for women.[35] The need to focus on women's health beyond maternal and child health is particularly important since many government health programs focus heavily on maternal and child health at the expense of other critical healthcare concerns faced by women.

It is critical to use a gender lens in the design and implementation of insurance schemes[36]. Gender-neutral policies that reduce the cost of accessing social benefits may increase utilization among women. However, they may still fail to reduce gender disparities because men may benefit as much or more than women because of gender bias[37].

Perverse incentives driving unnecessary procedures for women

The absence of adequate regulation of the private medical sector including costs of treatment and standard treatment guidelines creates adverse incentives for unnecessary medical procedures on women. At the same time, processes for obtaining informed consent or decision to operate heavily weigh in the favour of clinicians with decisions about surgery left mostly to the doctor.[38] Women are particularly likely to be excluded from such decisions.

The mean cost in the case of caesarean section delivery was Rs 1823.67, Rs. 4232.87 and Rs. 9754.67 in public, municipal and private institutions[39]. Unsurprisingly, caesarean delivery rates are alarmingly

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[29] https://www.nber.org/system/files/working_papers/w28972/w28972.pdf
[30] http://rchiips.org/nfhs/NFHS-5Reports/NFHS-5_INDIA_REPORT.pdf
[31] https://repository.iimb.ac.in/bitstream/2074/11948/1/Sen_GPH_2008_Vol.3_Supl.1.pdf
[32] https://documentation.ehesp.fr/memoires/2012/mph/cerceau.pdf
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7881649/
[34] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10352-4
[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6035505/
[36] Rodin J. Accelerating action towards universal health coverage by applying a gender lens. *Bull World Health Organ* 2013;91:710–1. 10.2471/BLT.13.127027
[37] https://web.stanford.edu/~pdupas/DupasJain_WomenLeftBehind_BSBY.pdf
[38] https://pubmed.ncbi.nlm.nih.gov/22864078/
[39] https://www.researchgate.net/profile/Gneyaa-Bhatt/publication/232321984_A_cost_analysis_of_deliveries_conducted_in_various_health_care_settings_in_a_city_of_India/links/0fcfd508288c7c9641000000/A-cost-analysis-of-deliveries-conducted-in-various-health-care-settings-in-a-city-of-India.pdf

high in private hospitals. In West Bengal the caesarean delivery rate in private hospitals is 71% compared to 19% in public hospitals; nearly 55% of all caesarean delivery was contributed by private hospitals.[40] The median delivery cost in private hospitals was more than three times higher than the public hospitals for both caesarean (INR 5000 for public hospitals; INR 16600 for private hospitals) and non-caesarean delivery (INR 2100 for public hospitals; INR 8600 for private hospitals)[41].

Across India, 70% of all hysterectomies are performed in the private health sector[42]. Across India, women in households with health insurance were almost two times more likely to have hysterectomies than women in uncovered households[43]. A study in Gujarat found that hysterectomies were reported for 7.2 % of women having insurance while only 4.0% of uninsured women had done so; a third of all hysterectomies were in women younger than 35 years of age.[44] A study from Andhra Pradesh found that 60% of hysterectomies were carried out on women aged under 30 and 95% of the operations were done in private hospitals; the hospital discharge summaries of these operations were mostly blank, with no information about the procedure or the follow-up instructions.[45]

Another study in the same state found that eligibility for the Aarogyashree insurance program increased the average prevalence of hysterectomies by approximately 116.7% compared to the women without access to state health insurance in non-AP states; 75% of all the hysterectomies were performed in the private sector.[46] Investigations by the National Human Rights Commission in 2017 found that patients who agreed to hysterectomy procedures were often misled by doctors and suffered health complications[47]. Women later complained of backaches, weakness, prolonged tiredness, chest pain and even partial vision loss.

Gynaecologists also perform ultrasounds without indications in pregnant women who complain of insignificant abdominal pain, then fabricate false reports of cervical abnormalities and advise the women to have cervical stitches, with the pretext of preventing miscarriage[48]. Illegal sex determination tests in violation of the Pre-conception and Pre-natal Diagnostic Techniques (prevention of misuse) Act have also been reported to be undertaken by private hospitals.[49]

Private hospitals do not deliver quality healthcare

Despite the higher charges in private hospitals, they often lack basic standards of care. Thus, in one study in Maharashtra, of 261 hospitals visited, 146 provided maternity services yet 137 did not have a qualified midwife, and though most claimed they provided emergency care, including caesarean section, only three had a blood bank and eight had an ambulance.[50]

[40] https://www.sciencedirect.com/science/article/abs/pii/S2213398420301561
[41] https://cegh.net/article/S2213-3984(20)30156-1/pdf
[42] http://rchiips.org/nfhs/NFHS-5Reports/NFHS-5_INDIA_REPORT.pdf
[43] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5756367/
[44] https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2811%2937553-2
[45] http://prayaschittor.org/wp-content/uploads/2015/11/Hysterectomy-report.pdf.
[46] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4084356
[47] https://www.indiatoday.in/india/story/national-human-rights-commission-hysterectormy-karnataka-maharashtra-963223-2017-03-01
[48] https://www.business-standard.com/article/news-ians/indian-private-hospitals-treat-patients-as-revenue-generators-115022500605_1.html
[49] https://timesofindia.indiatimes.com/city/chandigarh/pndt-racket-busted-in-private-hospital-at-kurukshetra-woman-tout-held-with-rs-34k/articleshow/89371645.cms
[50] https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2811%2937560-X?needAccess=true

At the same time, private hospitals are not free from obstetric violence[51]. By some estimates, the levels of obstetric violence in private hospitals may be in the vicinity of 40.9% which may have doubled from 27.7% in 2005-06.[52] Private sector facilities performed worse than the public sector for not allowing birth companions[53]. A cross-sectional community-based study in rural Varanasi[54] district in 2015, did not find a statistically significant difference in the extent of abuse in private and public health facilities.

Health as a commodity and not a right

Despite the many flaws of the private sector, a popular perception amongst Indian women is that it provides better amenities and a higher standard of care. [55] Women with previously negative pregnancy outcomes tend to choose the private sector.[56] However, this may be more of a choice based out of necessity in the face of chronic neglect and underspending in the public system, rather than a reflection of objectively good services being delivered in the private sector. In the words of a woman patient in one of the researches on the topic, *"In a private hospital, they will look after well for the greediness of money… If we go to the government hospital, they do not care about us." (Pregnant woman, Gulbarga).*[57] Women from more wealthy households, Muslims (unlike SCs and STs) and the general caste were more likely to access the private sector for healthcare[58]. Studies point toward a widespread perception that government hospitals are for the poor and that the private sector is geared towards the rich.[59] This relegates public sector provision as being a poor quality service meant for the poor and converts health from a right to a commodity.

Underrepresentation of women in the healthcare sector

A critical reason why women are voiceless in hospital settings is the inadequate representation in the medical profession, particularly in leadership positions. Only 17% of all allopathic doctors and 6% of allopathic doctors in rural areas are women[60]. The medical profession remains gendered with strong patriarchal norms. In a study of women oncologists, 28% reported facing gender discrimination; only 27% of them worked in departments with a woman leader.[61] Of the 31 members of the National Medical Commission, only seven (22.6%) are women; only one in five of its current Presidents and Chairpersons are women. [62] While women outnumber men in medical courses across the country[63], there is also a gap in women's leadership in medical education[64]. Medical education in India also

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[51] Obstetric violence is the physical, sexual, and/or verbal abuse, bullying, coercion, humiliation, and/or assault that occurs to laboring and birthing people by medical staff, including nurses, doctors, and midwives.
[52] https://www.womensweb.in/2020/11/obstetric-violence-indian-hospitals-assault-on-rights-dignity-of-women-nov20wk2sr/
[53] https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0668-y
[54] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-1970-3
[55] Thind A, Mohani A, Banerjee K, Hagigi F. Where to deliver? Analysis of choice of delivery location from a national survey in India. BMC Public Health. 2008;8(1):29
[56] Pomeroy AM, Koblinsky M, Alva S: Who gives birth in private facilities in Asia? A look at six countries. *Health Policy Plan* 2014, 29 Suppl 1(suppl 1):i38–i47.
[57] https://link.springer.com/article/10.1186/s12884-015-0481-8
[58] https://cegh.net/article/S2213-3984(17)30112-4/fulltext
[59] https://link.springer.com/article/10.1186/s12884-015-0481-8
[60] https://journals.sagepub.com/doi/abs/10.1177/0972063416665932
[61] https://www.clinicaloncologyonline.net/article/S0936-6555(18)30436-9/fulltext
[62] https://www.nmc.org.in/about-nmc/members-of-the-nmc/
[63] https://www.dnaindia.com/mumbai/report-girls-outnumber-boys-in-medical-courses-across-the-country-1915444
[64] https://blogs.bmj.com/bmj/2015/07/31/anant-bhan-gender-gap-in-medical-education-leadership-in-india/

lacks a strong gender focus[65]. More needs to be done to change gendered power relationships in the medical profession.

Legal and policy framework

India lacks legislation providing for a Right to Health, although it could be derived from the Right to Life under the Constitution. The Constitution protects the right to equality for women. Both international[66] and domestic[67] law includes specific protections related to sexual and reproductive health and rights. When it comes to the regulation of private hospitals, existing regulatory mechanisms are weak. Existing provisions include the Clinical Establishment Act (CEA)[68] and the Patients' Rights Charter which place obligations on private hospitals. A review of the extent of implementation[69] of CEA 2010 shows that all five crucial aspects of the regulation of clinical establishments are yet to be implemented. The National Council for Clinical Establishments approved an updated Patients Rights Charter in August 2021.[70] This provides a consolidation of various rights which enable the assurance of protection and promotion of Human Rights of patients and works as a guidance document for the Union and State governments to formulate concrete mechanisms so that patient rights are given adequate protection. In the Charter, specific women related rights include the privacy of women patients and non-discrimination in treatment based on gender.[71]

Recommendations

A. Overarching recommendations for ensuring equity and accountability and regulation of the private health sector in India

- Notify a right to health that makes it obligatory for the government to ensure equal access to timely, acceptable, affordable and gender-sensitive healthcare of appropriate quality to all its citizens, address the underlying determinants of health and regulate privately provided healthcare in India. This needs to place a comprehensive emphasis on ensuring India's health system is responsive to women's health needs, particularly beyond the reproductive and child health domains.
- The MOHFW and state governments must ensure that all states and Union Territories adopt and implement the CEA and the Patient's Rights Charter as soon as possible. The extent of implementation of the CEA should be monitored.
- The MOHFW must ensure that all States and Union Territories mandatorily display the Charter in all private and public hospitals.
- Regulate private hospitals to address financial exploitation, unnecessary diagnostics, medication and surgical interventions and all unethical practices. The Union and state governments should declare the standard price list and standard treatment guidelines for private hospitals to control unethical and malpractices, including those that impact women. Strong steps must be taken to stop unnecessary procedures.
- The government should strengthen grievance redress mechanisms to ensure that these are easy to access, prompt, people-friendly and gender-responsive. This would entail establishing functional helplines in tribal and other local languages and streamlining mechanisms for informing complainants about the status of complaints and providing for auto-escalation of the same if unresolved in time.

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[65] https://science.thewire.in/health/gender-equity-in-indias-health-education-is-still-out-of-reach/
[66] https://www.ohchr.org/en/node/3447/sexual-and-reproductive-health-and-rights
[67] https://www.legalserviceindia.com/legal/article-3372-reproductive-rights-for-women-in-india.html
[68] http://www.clinicalestablishments.gov.in/
[69] https://www.oxfamindia.org/knowledgehub/workingpaper/analysing-regulation-private-healthcare-india
[70] https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1797699
[71] http://clinicalestablishments.gov.in/WriteReadData/8431.pdf

B. Recommendations for addressing the specific challenges faced by women

- Ensure compulsory gender audit of all insurance and other PPPs schemes looking at the experiences of women, particularly on issues beyond maternal health, to address a full range of unmet healthcare needs.
- Set up a national rights-based surveillance system on women's health including sexual and reproductive health and communicable and non-communicable diseases based on culturally competent and women-friendly guidelines. More mixed-method studies with larger sample sizes exploring the health system limitations, provider behaviour and the experiences of women are needed.
- Develop training modules and conduct regular training programs for sensitization of medical students, practising doctors and medical staff (working in public and private systems) on gender to comprehensively address socio-cultural factors and gender bias in a range of health conditions, including those beyond maternal and child health-related issues. It includes clinical ethics and soft skills training for healthcare providers with emphasis on key ethical principles like autonomy, respect and dignity and on doing no harm. These are crucial to address the widely reported obstetric violence as well as provide gender-sensitive and ethical health care.
- Enforce medical ethics, conduct regular clinical audits and undertake exit interviews and social audits. Strengthen monitoring of private hospitals, especially those that are part of insurance schemes to improve women's experiences.
- Undertake mass campaigns to change broad social gender norms about women's health and promote health-seeking behaviour by women. This should include a strong focus on sensitizing men.
- Include women's rights organizations in the regulatory bodies and committees under the CEA at the district and state levels.
- Take steps to promote women's leadership in the medical profession including faculty in all disciplines and various medical bodies including the National Medical Council.

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2022