# The Political Prioritization of Child and Maternal Health:

# A Gender Analysis of National Health Policies in South Asia

A Senior Honors Thesis for the Department of International Relations

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Abstract:

The “gender gap” is used in current political discourse to describe the differences between men and women as voters. It is important to note that the gap does not just exist on the constituent level, as gender differences may continue to influence leaders once they take power. Existing global research on women's involvement in politics shows a connection between increased female representation in legislative bodies and more political attention geared toward social issues, such as education and healthcare. While this has been demonstrated in a variety of contexts of lower-levels governments, there is a serious lack of scholarship on the effects of having a woman in a position of national leadership.

This study investigates changes or consistencies in a country's developmental health policies when a woman holds the position of prime minister for the first time. A case study approach, using India under Indira Gandhi, Pakistan under Benazir Bhutto, and Bangladesh under Khaleda Zia and Sheikh Hasina, will track health policies implemented by a woman prime minister of a low-income country. Maternal and child health policies are used as indicators for this paper, on the basis of addressing issues both gendered and universal in scope. Ultimately, there is evidence to support more national attention toward maternal and child health under a woman prime minister, which has many crucial implications for future policies and analysis.

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# Introduction

Until I lived abroad during my junior year of college, I had never felt the impact of government policies on my own health. In the United States I always received exemplary healthcare through my parents' insurance, and while I heard and read about the problems with healthcare in our country, facing these problems was not a reality for me or my loved ones. Even so, while abroad in the Netherlands I was shocked by the ease with which everyone could access reproductive health services. The debate surrounding reproductive rights in the United States stood in stark contrast to the availability and culture of good sexual health. Thanks to the liberal nature of the government, even noncitizens in the Netherlands are allowed free diagnosis and treatment for most conditions. When I spent my second semester abroad in Israel, I again witnessed a stark contrast to my experience in the U.S. It became abundantly clear to me that the bureaucratic nature of a nation's government and its internal infrastructure dictate healthcare. In Israel, unless one was able to navigate the complex healthcare systems, which used many factors of a person's life to determine the care they received, getting even the most basic services was a struggle. I saw that health is not created equally—something I had learned in theory but not in practice.

This exposure to other cultures and systems of government made me realize the extent to which I had "normalized" my own experience. I questioned things that I had taken for granted, and I was finally able to pinpoint a frustration I had held onto since grade school. When I was five years old, I told my teachers that I wanted to be the first female president of the United States. My teachers (who were all women until the seventh grade) nodded in awe and encouragement. As I got older, the responses changed; I began to hear that our country still had a

long way to go before a woman, let alone a Jewish woman, would become president. Dozens of times we had to memorize names of former presidents, or famous innovators, all of whom were men. Why was it was so taboo for anyone to mention that we could really use a woman in office? Why is that still taboo? Simply telling a child they can be whatever they want to be does not instill in them the opportunities and resources to succeed. If children do not see a glimmer of themselves in who they aspire to be, it will not be long before that aspiration is extinguished.

My undergraduate experience at Tufts University was largely shaped by my focus on global health and women's studies. I crafted my major in International Relations to accommodate those interests, and found that they complemented one another perfectly. When I decided to write a senior thesis, I wanted to once again incorporate international politics with health and gender. Due to my interdisciplinary interests and experiences, I formed a study that allowed me to look at big picture concepts with important and practical implications. I have always been frustrated by the shortage of women in positions of power—so far fewer than the 50% of the population that we comprise. I firmly believe that unless diversity in leadership positions reflects the demographics of the populace, elected officials will not be able to properly serve the interests of their constituents.

It is truly the culmination of my personal experiences and beliefs that led me to write this thesis, in which I seek to understand how women in positions of power respond to the unique problems of their gender. I employ a theory called substantive representation to test whether women represent "women's issues" when they are elected into office. I use maternal and child health as the metric to measure "women's issues", as I believe its importance has been minimized until very recently. Mothers are the backbone of society, and children are the future. Without them, progress in society is unattainable. Thus, I pose the question: is increased

attention toward maternal and child health observed when a woman is prime minister of a low-income country?

I used case studies to form my analysis, and found that counterfactual evidence posed the greatest problem in answering this research question. Selecting a case study as a counterfactual example would mean examining whether having only men as prime ministers led to a consistent de-prioritization of maternal and child health. This standard approach to social science research does not fall in line with the aim of the study: to determine whether trends can be observed across countries that have had both men and women as prime ministers. In other words, I am testing a theory that looks at women and corresponding women's issues, rather than a direct comparison between men and women as individual leaders. This paper represents preliminary research on the trends in women as leaders of low-income countries, and how they affect health policies. Additional research that aims to draw connections between gender, health, and political leadership should continue in the hopes of bettering systems of equality in society.

# Chapter 1: Background

## The Gender Gap in Politics

There are many gaps that exist within the perceived norms of every culture and society. In general, gaps occur between the generations, the rich and the poor, the religiously observant and the secular, among others. Some may view these gaps as "natural" differences, while others view them as concepts to be understood in order to affect change and instill progress in society. In reference to politics, the most common meaning of the term "gender gap" is a clear difference in voting behavior, party preference, or political attitude and opinions between men and women (Kaufmann and Petrocik 1999). The ideas behind this gender gap lay the foundation for further

research that explains the intersection of gender and politics. Here, it is further hypothesized that an important separation exists in ideology, experience, and worldview between men and women that manifests itself in political leadership. In contemporary feminist and gender writings, the distinction between gender and sex is crucial—because ideology, experience, and worldview are socially and culturally constructed rather than biologically ingrained, and to avoid the implication that one's biological sex confines them to a specific gender, this paper will use the binary terms "man" and "woman", rather than "male" and "female".

## Differences in Ideology between Men and Women

The gender gap itself, expressed as the actual trends in voting patterns among men and women, has not always divided along the same party and ideological lines. When women were first granted suffrage in the United States they were expected to vote as a block, and to some extent they did; from the time that women were first enfranchised in 1919 until the 1980s, women voted more conservatively that men (Inglehart and Norris 2000). This was a disappointment to suffragists who believed that women, once enfranchised, would continue to advocate for progress from their newly legitimized perspective (Little et al. 2001). In the early twentieth century, women's confinement to certain roles in the labor force roles explains why they were largely apathetic and apolitical, and their ideological preference for the right is thought to stem from traditional religious and cultural modesty (Little et al. 2001). Other Western democracies saw minimal gender differences in voting behavior and party preference during that time frame, and thus some believed the concept of a gender gap to be unique to American politics.

Inglehart and Norris (2000) used data from the World Values Surveys (WVS), a global research project that annually measures various values and beliefs in over 100 countries

worldwide, to determine "gender differences in voting intentions". They created a ten-point scale to rank the survey results from the early 1980s, the early 1990s, and the mid 1990s. Inglehart and Norris (2000) found that by the 1990s a global shift in ideology had taken place, known as "gender realignment" or the "modern gender gap", in which women's voting patterns shifted from right-wing/conservative views to left-wing/liberal views. The authors accounted for gender differences that were preexisting within social classifications such as religiosity, class, age, or participation in the work force, and found that none of them impacted the shift of gender realignment. The causes of the modern gender gap are attributed to both structural and cultural forces, as the shift is strongly linked to the process of economic and political development. Because the gap was most pronounced in younger generations of post-industrial societies, Inglehart and Norris extrapolate the findings to suggest that women will most likely continue to move leftward in ideology (2000).

Gender differences in ideology among voters are important for politicians as they attempt to appeal to certain constituents. However, there is also a crucial implication for leaders themselves, and how their gender may be an influencing factor in their political ideology. Inglehart and Norris's (2002) findings show that as societies develop, and women become more integrated into the social and political realms that were previously exclusive to men, their left-leaning views actually become more pronounced. In recent years, women have broken many glass ceilings and made progress in all realms of the public and private sectors. Women's roles in various arenas—the economy, politics, religion, health, and the military—have expended in scope and power, and access granted to women has increased (Smith and Ward 1984). However, the struggle for true equality of rights and opportunities between men and women is far from over. Cottingham and Myntti (2002) recommend an in-depth gender analysis, which "examines

how the social system, from public policy and health services to private intimacy, incorporates inequalities of power between women and men" in order to reveals the pervasiveness of those systems within society (p. 83).

## Defining "Women's Issues" in Politics

In contemporary as well as historical literature, "women's issues" tend to be defined as healthcare, childcare, and social reforms like education and human rights (Kudva 2003; Little et al. 2001). These are also referred to as "soft issues" in political discourse (Chowdhury 2009). The true origin of this association is unknown—although it is deeply ingrained in the minds of many electorates—and a presentation of the debates seeking to explain the cause of gender differences using the "socialization versus biology" arguments are beyond the scope of this paper. At the heart of the matter are the effects of gendering the aforementioned issues within mainstream political discourse. When assigning certain issues a gender, the question becomes whether they are then subject to a different kind of political attention or approach. There is no true equivalent for men and corresponding "men's issues"; while some studies do assign issues such as taxation or national security a "masculine" gender, it is consistently in response to the "feminization" of other issues. The contradiction here is that even if the root of gendering a political issues can be found in the historical dealings with said issue—women were traditionally caretakers and men were traditionally involved in labor and business dealings—politicians today continue to use "women's issues" to appeal to their women candidates. This demonstrates that women's involvement in politics remains outside of the normative structure of political systems and the relationship between the politician and the constituent. The gendered aspect of this discussion on issues that affect the human population, and the inconsistency of assigning certain

issues as pertinent to women (only), further emphasize the depth to which inequity surrounding gender is entrenched in society.

Although politicians do not speak of "men's issues" when talking to constituents or appealing to voters, as they do with "women's issues", a gender binary exists in the literature on women and international relations. Goldstein (2003) explains how war has been gendered in all respects—from depictions of soldiers as strong men, to the phallic nature of weaponry and the feminization of enemies. It is clear that powerful state actors have starkly masculine connotations. Peacemaking, on the other hand, is seen as a largely feminine operation, as well as an explicit goal of feminism itself. In a close examination of the reasoning behind this binary, evidence from many sources was considered: historical accounts of war, the physiology behind claims of strength, and biological reasoning behind the apparent connection between male hormones and violence. Interestingly, this examination revealed that the arguments supporting the stark gender binary hold very little water, but they do continue to support inequality and discrimination of women in handling state security today (Goldstein 2003). Goldstein's evidence that men and women are actually more alike in the realm of war than most people believe gives rise to an interesting dilemma: is there a difference at all in the ways that women utilize power—both politically and in terms of force—as compared with men? With the potential for historic gendering of issues to feed into the perceptions of policymaking today, it becomes even more important to understand that issues such as health and education are coded as women's issues.

## Theories of Gender in Political Representation

A discussion of gender differences in politics is not new to scholarship, and as such there are established terms and discourse to describe the behaviors of political leaders, whether men or women, and their policies. Substantive representation and descriptive representation are two

primary theories of political approach that have been used to explain the actions of political leaders within legislative bodies vis-à-vis their constituents. Lena Wangnerud is a Swedish political scientist who has written extensively on women in parliaments, and her definitions will be used in this paper. Descriptive representation has a longer academic history, and the research is focused on "the numerical distribution of seats between men and women" (Wangnerud 2009, p. 52). For a legislative body to be considered wholly "descriptive", the percentage of various demographics represented in the body should be equivalent to that of the electorate, in an attempt to accurately represent both the makeup of the population as well as their needs and interests. It should be noted that unless the electorate is fairly uniform, descriptive representation rarely occurs naturally.

Substantive representation is much less measurable, as it considers the actual effects of having women represented in politics. Research on substantive representation essentially seeks to determine "what women do in parliaments" (Wangnerud 2009, p.59). Do they advocate for women's interests? Do they take part in the existing patriarchal structure, or forge their own paths? Wangnerud (2009) selected indicators to determine whether women in parliaments advocate for women's interests, including gender differences in attitudes, prioritization of issues, and support for outside organizations. She concluded that "female politicians contribute to strengthening the position of women's interests" (p. 65). However, most of her paper is dedicated to showing the shortages in research and gaps in knowledge regarding women as politicians.

Although Wangnerud demonstrated the existence of substantive representation for women members of parliament representing women's interests, she also spent a large portion of her paper discussing the problems in research on substantive representation. According to her,

too much emphasis is placed on "the extent to which the number of women elected affects women's interests" (Wangnerud 2009, p. 52). This approach is often referred to as the concept of critical mass, and its effects are debated within the literature in this field. Some studies show how a critical mass—generally hovering around 20 percent—of women in political bodies is necessary to produce change, while others place the importance of the political system itself over the mere number of women represented (Paxton et al. 2007). Wangnerud cites Phillips (1995) to further describe the challenges of research on women in legislative bodies:

> "The theory of the politics of presence suggests that female politicians are best equipped to represent the interests of women; thus, the theory predicts a link between descriptive and substantive representation. Phillips's argument is built upon differences between women and men in their everyday lives, such as differences relating to child-rearing, education and occupations, divisions of paid and unpaid labor, exposure to violence and sexual harassment, and the fact that female politicians, at least to some extent, share the experiences of other women. Few deny that gender-related differences exist in contemporary societies; however, the connection to the political sphere is disputed. Phillips herself used the expression a "shot in the dark" (1995, p. 83) in reference to expectations for female politicians to affect politics in any specific ways. Her doubt stemmed from her knowledge about rigidity in political institutions; parliaments do not change easily." (p. 52)

Wangnerud concluded that more research is necessary to bolster the theory of substantive representation. While her focus is mainly on the Nordic countries, she believes that the "perspective has to be widened" due to the implementation of gender quotas worldwide and

subsequent increase in women's participation in legislative bodies, varying from national to local levels (p. 53).

## Women's Political Leadership

While women have held leadership positions as monarchs for centuries, this paper will focus on the importance of women in elected positions of government. Only recently have women begun to hold titles of president and prime minister in their national governments. This occurred for the first time in history in 1960, when Sri Lanka (then Ceylon) elected Sirimavo Bandaranaike into the office of prime minister. The first woman president, Isabel Peron, was appointed into office in Argentina in 1974 after serving as vice president to her husband, Juan Peron, who passed away in office. Six years later, a woman was elected as president in Iceland. To date, 17 countries have had more than one woman in their highest elected office, and out of the ten most populous nations in the world, five have had a woman as head of state. This paper focuses on three countries (listed in alphabetical order) in South Asia that have all had women prime ministers: Bangladesh, India, and Pakistan.

### Achieving Political Power

Since the 1960s, the number of women holding positions of state or national governments in South Asia has increased dramatically. The rest of the world tells a different story; although the United Nations called for the "Decade of Women" in 1975, the following twenty years saw only a half percentage point increase in the amount of women in national parliaments worldwide (Pellegrino et al. 2010). Only in the 1990s did the talk of women's empowerment become a reality, and governmental representation increased for women worldwide (Pellegrino et al. 2010). This increased representation appears somewhat contradictory in the South Asian context given the many gendered institutions and traditional social norms that remain in that region.

Child marriages, widow burning, bride prices, and honor killings are everyday realities in some regions, and access to education and other resources is limited for many women and girls (Jayaweera 1997). The explanation of this dichotomy for many South Asian countries can be found in a mandated system designed to battle the numerical inequality of representation in government between men and women. In order to combat this inequality and promote inclusions, gender quotas or seat reservations were implemented in the late twentieth century in Afghanistan, Pakistan, Bangladesh, India, Nepal, and Sri Lanka (Fleschenberg 2007).

There are many different types of quota systems, and in fact almost half of all countries have some sort of gender quota in place (Dahlerup 2007). One type, mainly used in South America and Europe, is known as a "candidate quota", which insures that a certain percentage of aspiring or actual candidates in an election are women. This type of gender quota is aimed at increasing equality of opportunity between the genders without mandating results; because seats are not technically reserved for women in government, this system emphasizes fair competition and leaves the control in the hands of the electorate. In South Asia and the Arab world, the most common type of quota system is a "reserved seat quota", which ensures that a certain percentage of people (such as women, minority religions, or marginalized castes) are actually elected and hold a predetermined number of seats in parliament. This system works to achieve equality of results, and some would say that it does so at the expense of merit and competition (Dahlerup, 2007).

Quota systems are not without their flaws, which may explain why they are not instated in more countries around the world. While quotas are seen as an effective, fast-track way to increase women's representation in legislative bodies, tokenism remains a problem for women in the political sphere and is often exacerbated by quota systems (Dahlerup 2007). Fleschenberg

(2007) articulates how gender quotas, and the fact that a woman's place in leadership must be reserved in order for her to get there, reflect the culture of gender stereotypes that pervades private and public spheres alike: "Asian women [are] selectively integrated as *women* into politics… while men are integrated as politicians" (p. 4). This concept also harkens back to the normative quality of men's participation in the political sphere, and the "masculine" nature of the system within which the woman must navigate and prove that she belongs. There is evidence to support a variety of outcomes with respect to the effects of engineering elections through quotas and reservations in South Asia (Fleschenberg 2007; Dahlerup, 2007). Essentially, these scholars are asking whether quotas are merely a symbolic gesture, where women are essentially used as tokens within an exploitive system, or if there is meaningful and observable change that stems from having a woman in office.

Not all types of women are represented in politics through gender quotas. In India, interviews with women (n=11,488) regarding their participation in local and state government showed that only women who have a self-proclaimed identity apart from their household and exercise some form of autonomy are likely to participate in government, and thereby take advantage of the allotted reservations (Chhibber 2002). Chhibber (2002) used the WVS to extrapolate this finding to other countries and settings; the survey question "how often do you meet with friends" was taken as an indicator of having an identity outside of the home. Reponses to that question had a direct correlation to responses regarding "political activity" for women, whereas there was no significant association for men. Although this study does not equate a self-proclaimed identity with a higher socioeconomic status, other scholarship is concerned that the poorest and most marginalized women are still not able to achieve political power (Jahan 1987). In essence, whether or not gender quotas are symbolic tokens of women in politics or tools that

affect observable change, there is still a discrepancy between the variations in the electorate versus the women who participate in politics.

### Public Perception of Women as Leaders

The ways in which women are viewed as politicians, both by their own constituents and by the electorate as a whole, lends crucial insight into the reasons for why people might or might not vote for a woman on the basis of gender. A survey of randomly selected US voters (n=696) shows that gender, education, and ideology are strong indicators of presidential gender preference. Specifically, being a woman, having a higher level of education, and identifying as a liberal are all statistically significant indicators of believing a woman would do a better job as president (Kenski and Falk 2004). When controlling for socio-demographic variables, naming healthcare as the most important problem for the US is positively associated with thinking a women would be better than a man as president, whereas naming taxes as the most important problem is positively associated with thinking a man would be preferable (Kenski and Falk 2004). This research displays the actualization of "women's issues" as perceived and internalized by voters. Again, there are issues inherently associated with women that affect the perception of their ability to achieve success in certain realms of the public sphere.

In 2006, Campbell and Wolbrecht published research on the effects of "women politicians as role models for adolescents". The results of their study conducted in the United States found that girls who were exposed to women in positions of political power during their adolescence are more likely to discuss politics with friends and indicate an intention to run for office one day, compared with adolescents who were not exposed to women politicians. In 2007, using the European Values Survey, Campbell and Wolbrecht extrapolated this finding to conclude that the same correlation between talking about politics and indicating an intention to

go into politics applies for adolescent girls in Europe when they are exposed to women parliamentarians. Therefore, being exposed to women in government during adolescence increases the likelihood that a woman would want to venture into the world of politics, as well as increasing awareness of politics and current events. Most countries in Europe do employ gender quotas in their parliaments and legislative bodies; if this theory proved true worldwide, it could be construed as evidence that a quota system would have a "ripple effect" on increasing the numerical representation of women in government as well as the diversity of the women participating.

In South Asia, the effects of quota systems on voter preferences are complex. In a random sample of Indian villages (n=495), some of which had experienced reserved seats for women in their local governments and some of which had not, researchers found that all villagers exhibited a strong same-sex preference when asked to evaluate different leaders. However, men in villages that had reserved seats for women "actually rated the effectiveness of a hypothetical female… above that of a male" (Beaman et al. 2012, p. 3). The research also showed that exposure to a woman leader in their village "significantly reduced male villagers' association of leadership activities" with men only (Beaman et al. 2012, p. 3). This finding is similar to the "role model" theory in that recognition and exposure of women in positions of power can be used as a paradigm shift for society and gender roles; women in the public eye, especially as elected officials, have the potential to change even the most ingrained cultural beliefs and practices of both genders—a hopeful sign for the move toward equality for women.

### Differences in Priorities for Men and Women Leaders

The trends in legislation emerging from members of US Congress (MOCs) also lend insight into the difference in political behavior based on gender. Surveys were distributed to 331

MOCs in 1997, asking about main legislative priorities (Little et al. 2001). Women were more likely to prioritize the traditional "women's issues" of healthcare, social services, environment, family life, and local issues, whereas men were more likely to prioritize "men's issues" of economic development, taxes, budget, public safety, government institutions, and insurance. In the study, these differences were statistically significant with respect to women prioritizing healthcare and social services, and men prioritizing the budget and public safety. Based on their findings, the authors argued that "women leaders support a distinct legislative agenda in spite of… pressures and potential selective recruitment biases" (p. 44). The political system itself and its intersection with gender has a large effect on leadership agendas; it is possible that women who represent political agendas or styles similar to their male counterparts may have an easier time getting elected, or conversely, women might feel the need to represent a distinct agenda to keep their spot in office. Even so, Little et al. (2001) maintain that "the gender of the leader appears to be the most significant indicator of the view from the top, having a more significant effect than party, race, experience, the nature of the position, or region" (p. 44).

Further studies show that when it comes to taking action, women in Congress are more likely than men to vote for said "women's issues" (Paxton et al. 2007). A 2007 review article analyzed global data on the aggregate effects of women's participation in government at national levels (Paxton et al. 2007). The authors found that "women are more likely than men to introduce bills to reduce gender discrimination and sponsor bills related to education, health care, children's issues, and welfare policy". This indicates substantive representation is present worldwide, and has major implications for policymaking that addresses social issues.

## Women's Political Involvement and Health Interventions

Historically, when women throughout the world began to enter government positions, they gained the unique ability to make visible certain issues that were not adequately addressed in the traditionally male-dominated public sphere (Bacci 1999). For better or for worse, women worldwide are perceived as caring more about and devoting more fiscal attention to health. This section addresses the connection between women's increased participation in politics at the local level and the health interventions that they propose or implement.

### Global Development

In their book Half The Sky: Turning Oppression into Opportunity for Women Worldwide, Nicholas Kristoff and Sheryl WuDunn (2009) show how the improved status and empowerment of women consistently leads to economic growth for the whole society. They offer crucial recommendations for low-income countries to empower women, such as microfinance loans and increased access to better education and legal protection. However, that is not to say that Kristoff and WuDunn have developed a formula for women's empowerment. If anything, their book was successful in bringing many global issues to light in parts of the world that do not struggle from the same problems. The authors admit that these problems are exceedingly complex, and their praise of individual women who have risen above oppressive circumstances does not account for the masses that are still hindered and abused every day because they are women. Clearly, a means to pervade patriarchal systems and create cultural and structural change is necessary in many parts of the world.

In 2012, a groundbreaking study with practical implications for women's empowerment found a similar pattern in terms of improved health status, especially for children, when women comprised at least 20 percent of seats in parliament. Swiss et al. (2012) conducted the first cross-

country and longitudinal research on this matter; they looked at child immunization rates and infant survival rates in 102 countries that had anywhere from 3 to 10 percent of women represented in parliament. They showed that "an increase in the percentage of women legislators has a significant and strong effect on child health, particularly in countries with lower social and economic development indicators. When national income and/or women's formal education is lacking, women's political power and presence becomes central to change" (Swiss et al. 2012, p. 549). By controlling for other variables, such as the nature of political systems and the presence of international interventions, the authors found a clear causal relationship between the legislative behavior of women and improved health of the community. The "specific mechanisms" of legislation, meaning what exactly was voted on or prioritized, was not examined.

These studies offer concrete reasoning why societies should focus on the economic and political empowerment of women; even if patriarchal or traditional gender norms constrain people from believing in the principle of gender equality, the practical implication regarding economic and health improvements should be considered by all stakeholders of a society—regardless of gender.

### Local Effects of Women's Increased Participation

Women who gain political power through gender quotas often act as the catalysts for improved health in their societies. Beaman et al. (2006) aggregated data from household surveys of villages in India to test their hypothesis that "women leaders are more likely to promote child health (in the form of immunization) and education" (p. 11). Their data showed that seat reservations for women in village governments are positively related to a child between the ages of 1 and 5 being fully vaccinated. A gender gap in school attendance was significantly decreased

when women held reserved seats. They also identified a statistically significant relationship between reserved seats for women in village governments and more water taps and hand-pumps. This means that women invested more in terms of funding and delivery of safe drinking water relative to men (Beaman et al. 2006).

In a preliminary draft of their study, Bhalotra and Clots-Figueras (2011) found that seat reservations in India are positively associated with increased investment in MCH, specifically more antenatal visits, higher probabilities of breastfeeding in the first 24 hours following childbirth, giving birth in a public facility, and full immunization by age one. Women's political representation in local bodies also led to statistically significant results with respect to more women giving birth in a public center rather than in their homes. When the authors factored in state health expenditure, they concluded that "a very effective way of encouraging women to give birth in public facilities rather than at home is to put female politicians at the helm and also that a fairly ineffective way to proceed is to improve growth or to raise state health expenditure" (p. 14). Through their involvement in local policymaking, women increased social spending and contributed to reducing poverty and prioritizing healthcare.

In the Indian state of Karnataka, where local governments have reserved 25% of seats for women since 1983, substantive representation was apparent through the approachability of women legislatures:

> Narratives show that village women found it easier to approach women representatives about issues that directly impacted their lives, which include getting the widow's pension promised by the government, obtaining water and electricity connections, adding rooms to the village school-house, or providing childcare in the community through government-run Balwadis. (Kudva 2003, p.454)

The approachability of women in local governing bodies is an important factor for improving the status and circumstances of women throughout the village. As a woman's place in society has largely been confined to the home through pervasive systems of patriarchy, their needs have often been misinterpreted or ignored. If women constituents feel more inclined to talk to women representatives, gender quotas and seat reservations represent yet another way that governments can begin breaking down the structures of patriarchy and include women's voices in policy.

## Maternal and Child Health Concerns

The primary health concerns that will be confronted in this paper are those that relate to mothers and children. The determinants of maternal and child health (MCH) are biological as well as social. Biological risk factors for disease are distinct from social risk factors for disease in that they are not entirely preventable, but their severity is largely impacted by social factors. Therefore, it is important to address both. Women's inherent biological risk factors include anemia related to menstruation and complications surrounding childbirth. Children are biologically vulnerable because they depend wholly on others to provide them with all of their basic needs. Poverty and education are important social determinants of MCH, the former yielding much worse outcomes and the latter drastically improving health (Skolnik 2012). The present study focuses on the most prevalent causes of maternal and child mortality. The ways in which political prioritization has been shown to increase awareness of important MCH problems will continue to be addressed throughout the paper.

### Maternal Health

The term "maternal health" refers to the health of the mother during pregnancy, childbirth, or the 42-day period after the baby is born (Skolnik 2008, p. 152). 20% of maternal deaths are considered indirect, meaning that they are caused by diseases that impact or

complicate those stages of a mother's life, and 80% of maternal deaths are caused by health problems specific to those three stages of motherhood (Skolnik 2008). Most of the problems associated with maternal health are preventable and have feasible policies that could address them. The most prevalent direct causes of maternal mortality worldwide include hemorrhage, infection and sepsis, eclampsia, and obstructed labor (Skolnik 2008). Inadequate access to emergency care facilities and trained health workers are factors that turn many of these complications into fatalities (Skolnik 2008).

Hemorrhage can occur before, during, or after the child is born, and involves a significant loss of blood from the mother. Hemorrhage is a dangerous physical reaction to internal complications, such as the inability of the uterus to contract properly or trauma from delivery. If a mother begins to experience hemorrhage, living in a remote location becomes the primary risk factor, as there is a higher chance of delaying access to crucial treatments, such as blood transfusions (Graham et al. 2006).

Childbirth itself poses a large risk of infection for the mother, which is why proper sanitation is crucial. Cutting the umbilical cord, performing a cesarean section or delivering the child vaginally all expose the mother to opportunities for bacteria to invade her body. If an infection is not treated immediately and becomes severe, there is a chance that the mother will go into septic shock in the six weeks following childbirth (Graham et al. 2006). While the infection may have gone unnoticed for weeks, a state of sepsis will present in the body through a severe inflammatory response: high fevers, elevated heart rate, altered mental state, hyperventilation, etc. Even if emergency care is sought at this time, there is a high risk that it will be too late to treat the infection, once again showing how access to healthcare facilities is a huge determinant of morbidity and mortality (Graham et al. 2006).

Many women also experience obstructed labor, which occurs due to complications in delivery, or when the mother's body is not equipped for childbirth. The latter largely stems from adolescent pregnancies and poor nutrition, positioning the mother's body to be disproportionately small or weak relative to the task of childbirth (Graham et al. 2006). Again, lack of access to emergency care in the form of a cesarean section leads to many preventable fatalities from obstructed labor.

Interventions to provide adequate maternal health care are crucial for mothers of all stages. As cited by Graham et al. (2006), the WHO estimates that "88 to 98 percent of maternal deaths are avoidable with moderate levels of health care" (p. 505). In terms of primary prevention, community education on motherhood needs and newborn care has a strong positive relationship with better MCH (Graham et al. 2006). Nutritional advice, provided through educational programs, can prevent anemia or other micronutrient deficiencies. The distribution of nutritional supplements, such as iron, folate, and vitamin A, is considered a cost-effective and important intervention due to the impact of nutritional status on the growth potential of the mother and child (Graham et al. 2006). Malaria, anemia, HIV/AIDS, and cardiovascular disease are conditions that also contribute to an increase in maternal mortality from natural complications of childbirth.

The matter of who attends a birth and how quickly/efficiently emergency care can be provided has the most direct impact on maternal mortality. A skilled health official with proper training can prevent many of these complications during delivery. Two other forms of interventions have a direct effect on maternal health: family planning and safe abortions. Both of these represent public issues with an ideological, legal or major policy component, and policymakers often focus on the mother's reason for seeking an abortion as a means of deciding

whether or not it should be legalized. Regardless of the motivation, if an abortion is not carried out by a trained health worker with the proper equipment and sanitation it poses great risks for the mother. It is estimated that over half of abortions are unsafe, and the mortality rate of an unsafe abortion is approximately 100 times greater than a safe abortion (Skolnik 2008). In general, family planning policies impact maternal health because there is a direct relationship between the number of children a woman has and her risk of maternal mortality. Before abortion becomes an option, contraception and other family planning methods could reduce unwanted pregnancies and decrease maternal deaths by 25-40% (Misra et al. 2003).

### Child Health

The main causes of death in children are often interconnected due to similar risk factors, and are also largely preventable or curable. For children in their first month of life (neonates), the main causes of death—low birth weight, respiratory infections, birth asphyxia, trauma, tetanus, and diarrheal disease—are all related to how and in what conditions the child was born (Skolnik 2008). In that regard, the importance of the mother's health and education is already clear. Diarrheal disorders (DD), malaria, and respiratory infections are the main causes of death in children between 1 and 5 years old, and represent the greatest burden on child mortality.

Diarrheal disorders (DD) are caused by a variety of bacteria, viruses, protozoa, and helminthes, which are transmitted through the fecal-oral route (Cairncross and Valdmanis 2006). Although they are not uniform in their causal agents, these disorders are grouped together due to their similar pathology and mechanisms for treatment and prevention. Deaths from DD are most prevalent in children whose living conditions include unsafe water, poor sanitation, and minimal hygiene (Taylor and Greenough 1989). In ideal circumstances, all children would have access to clean water. However, given that universal access has not been achieved, DD prevention

measures must take into account the resources available to populations at risk. Exclusive breastfeeding as a method of prevention works by eliminating a child's risk of contact with contaminated water, and was shown to be not only cost-effective, but also reduced morbidity up to 20% and mortality up to 27% in children up to six months old (Taylor and Greenough 1989).

There are a few relatively straightforward ways to manage cases of DD once children present symptoms. Treatment with oral rehydration therapy (ORT), a simple solution of essential salts, sugars, and water, is an extremely important and effective intervention (Taylor and Greenough 1989). ORT supplements the body with fluids that have been lost in acute watery cases of diarrhea, which is the cause of death in over two-thirds of cases. Also crucial is providing a child with adequate nutrition during the episode of diarrhea, and afterward to prevent recurrent attacks. Social mobilization for ORT, when geared toward political leaders, has been a successful method of prioritizing this global health issue. When presidents or prime ministers prioritize this issue, generally through media publicity, it shows their humanitarianism and effectively mobilizes other government workers. Political will, meaning a commitment to specific policies, helps ensure that programs that make financial sense are sustainable and receive continued backing from the government (Taylor and Greenough 1989).

Unlike many other global health challenges, malaria is neither invisible nor insignificant. Rather, governments and non-governmental organizations (NGOs) alike have devoted enormous amounts of resources to the prevention and treatment of this disease, with the long-term goal of someday eradicating it worldwide. Prevention methods for malaria have focused mainly on vector control through two methods: indoor residual spraying (IRS) and long-lasting insecticide nets (LLINs). Malaria can be cured through antimalarial drugs in most circumstances.

Malaria is caused by a bite from an *Anopheles* mosquito carrying one or more species of *Plasmodium* parasites. After *Plasmodium* enters into the blood stream, it may cause infection and can elicit significant pathology. While the severity of infection depends on the host as well as the parasite, it is common for children to experience the symptoms of fever, chills, headache, and vomiting (Crawley et al. 2010). When untreated, as if often the case due to the lack of distinguishing features that would set it apart from many other child health problems, it will progress to a cerebral malaria stage and cause coma or death.

Respiratory infections represent a large portion of illnesses with related pathology, including pharyngitis, ear infections, pneumonia, bronchiolitis and influenza (Simoes et al. 2006). According to Simoes et al (2006), the average child, regardless of sociodemographic factors or geographic location will have three to six respiratory infections per year. What differs between children born into high-income areas versus low-income areas is the scope of the illness, in terms of severity and fatality, based upon access to sufficient medical care and effective drugs. The critical primary prevention method is vaccinations in children to prevent meningitis and pneumonia (Simoes et al. 2006). Aside from that, early detection methods have been identified as an effective intervention crucial to child survival.

### The Vicious Cycles of Poor Health

For countries that struggle with poor MCH, poverty, and overpopulation, many vicious cycles come together to make combating these problems especially difficult. "There is adequate evidence worldwide that a poor society can get caught in a vicious 'fertility-mortality' trap, in which high fertility rates lead to high mortality rates and vice-versa" (Misra et al. 2003, p. 72). In other words, "the birth rate is high because people are poor, and people are poor because the birth rate is high" (Chhabra 1981, p. 170).

High birth rates impact the disproportionately poor health that girls face compared to boys in low-income countries, and contribute to the vicious cycle of poor MCH. While India holds the worst reputation for discrimination against girl children, it is also observed in Bangladesh, Pakistan, and many other countries (Pande 2003). When there is a shortage of resources for an entire family, and it comes to choosing which children receive more food and medicine, both boys and girls are adversely affected if they have older siblings of the same sex. However, when boys are born after girls, there is a clear son preference in the family structure. Specifically, girls are not fed as much, clothed as well, or given the same access to education and health care (Pande 2003). The acceptance of this norm, as well as the upward trends in sex-selective abortions throughout Asia, have dire consequences; there are now less girls present in the region, which further institutionalizes the belief that girls are less capable of contributing to their families and to society.

As young girls grow into womanhood, they continue to be more adversely affected by poor health. The same social factors of poverty, discrimination, and lack of education position girls to be hindered by the vicious cycle of malnutrition at every stage of their lives (see Appendix I; Haider 1995). Again this unfortunate pattern also exists due to the multisectoral determinants of health (Jamison 2006).

This vicious cycle has crucial implications for policy. Osman (2008) describes the intersectional nature of causes and remedies for children's health:

> Child health mainly depends on adequate nutrition, safe drinking water, sanitation, a clean environment and primary education, all of which are interconnected. Studies reveal a strong correlation between the status of a child's health and the level of his/her mother's education. NIPORT et al. (2007) shows that children of mothers with no education are

> more than twice as likely to be stunted (51 per cent) as children of mothers who have completed secondary and higher education (22 per cent). It also shows that children of more educated mothers are more likely than other children to be fully vaccinated. Therefore, mother's education must be a major policy focus in order to improve the child health status. (p. 284)

In order to overcome these vicious cycles, greater policy measures and on the ground changes need to bring the issue to light. Maternal and child healthcare represent a crucial way for policies to greatly benefit society as a whole and ensure a country's progress.

## Research Question

Is increased attention toward maternal and child health observed when a woman is prime minister of a low-income country?

### Hypothesis Testing

The null hypothesis will be tested in this analysis; evidence will be presented that will be used to reject or fail to reject the hypothesis.

**Hypothesis:** Women prime ministers are more likely than men to bring issues of maternal and child health to the forefront of national politics, indicating the existence of substantive representation on the national level.

**Null Hypothesis:** Women prime ministers are no more likely than men to bring issues of maternal and child health to the forefront of national politics, indicating no existence of substantive representation on the national level.

## Significance

The ways in which people interact with politics—through voting, ideology, participation, specific policies, et cetera—largely differs on the basis of gender. It is by no means the sole factor in said interactions, as other socio-demographic variables such as race, religion, age and regional ties have been shown to have a large influence as well (Crenshaw 1991). However, the trends that have been repeatedly analyzed in existing scholarship and the current push for more gender equality worldwide need not be ignored, but rather understood and grounded in specific policy issues. The literature points to an established link between women in political power and a push toward remedies for liberal social issues, such as education, sanitation, and other child-related health concerns. However, this marks a very apparent dichotomy in the discussion and viewpoint on gender in politics. On the one hand, trends in policymaking and voting provide evidence that women have a unique agenda geared toward social issues, health, children, etc. On the other hand, the argument for excluding women from positions of leadership in many arenas has been based off the idea that they only care about "soft issues", and would not have the courage or strength to make tough decisions. Both sides of the coin get to the crucial question: is there an "essential" characteristic of women that dictates their policy behavior?

Considering the vast scholarship that discusses women's representation in government, it is useful to locate the dialogue within a concrete and measurable context. Will the world see better MCH outcomes if there are more women leaders? Many states in South Asia and other parts of the world have put into place a considerably progressive policy of quotas for women to be represented in political bodies. Yet, in many cases these are the same states that are largely considered "developing", and hold some of the world's worst statistics with respect to infant and

maternal mortality, malnutrition, shortened life expectancy, infectious disease and HIV/AIDS prevalence. At the same time, the world looks toward the United States as a beacon of freedom and equality, but the fact remains that even the wealthiest and most "developed" superpower has not seen a woman in the highest elected position of government. This further demonstrates the limitations for women in existing political structures; it is not only women's lived experiences in low-income countries that prevent them from achieving a higher status in society, it is also the centuries-old subjugation of half the world's population in inherently patriarchal institutions.

Understanding the link between MCH and women in politics is crucial for development and future policies. The consequences of high child and maternal mortality are detrimental to society as a whole, as they cause a stoppage to growth and progress. Those who are stuck in the vicious cycles of poverty and malnutrition must cope with devastating losses, often of their own children, to preventable diseases. Those in positions of power must allocate enormous resources to health interventions that might not even scratch the surface of the problem. Comprehending how women approach these issues provides a glimpse into the future of the human population, and what will be important for continued advancements in both health and politics. Women in power are the ones at the forefront of addressing these issues; it is crucial to not only ask *why*, but also *how* to harness the benefits of substantive representation into even greater spheres. Specifically, will health and the chances of survival be improved if we have increased political empowerment for women? Is the connection between MCH and women leaders another reason to further establish a precedent of women in the highest positions of political power?

Contemporary research and development supports this linkage. Women's empowerment is an extremely relevant topic in global politics and social movements. Each of the Millennium Development Goals, established by the United Nations in 2000, is highly linked to maternal or

child health (Skolnik 2012). The Global Gender Gap Report, published by the World Economic Forum in 2012, outlines four pillars that constitute the gender gap in society: economic participation and opportunity, educational attainment, political empowerment, and health and survival (Hausmann et al. 2012). It is now up to policymakers of all kinds to interpret how these indicators of the gender gap will be addressed and remedied. This paper speaks to the latter two pillars and hopes to provide new recommendations for their betterment.

# Chapter 2: Methods

## Case Study Approach

Based on the methods that Croghan et al. (2006) used to determine "routes to better health for children in four developing countries", the present study uses retrospective case studies to approach the research question. Cases for this study were also selected at the country level. In seeking to conduct a comparison across countries, the following factors were set as constants for all chosen countries: geographic location, colonial history, parliamentary system of government, and relative stage of development. Similar to the "country selection" method used by Croghan et al. (2006), these factors were chosen somewhat arbitrarily in order to minimize outliers. A fair amount of variation in regards to religious, cultural and political differences between countries still exists, but that is largely unavoidable and to be expected from international research.

The following are the two exclusion criteria that were established: (a) a woman must have served as prime minister, and (b) significant MCH problems needed to be present at the country level. The countries that were chosen based upon all of these considerations are India, Pakistan, and Bangladesh (presented in chronological order of the country's first women prime

minister). The fact that each chosen case had a woman prime minister who served multiple nonconsecutive terms in office was not an original requisite, but allows for a greater breadth of analysis spanning different contexts. Moreover, India, Pakistan, and Bangladesh each formulate national policy through the implementation of "Five Year Plans", which offers consistency in tracking policy decisions and priorities.

## Data Selection

### Health Indicators

Many studies in global health use one or more health indicators to measure and trace various results. These indicators may consist of the actual status of health or the determinants that lead to such a status. Ideal health indicators are defined by Croghan et al. (2006) as "measurable indicators that would allow for cross-country comparisons over time"; they are further categorized as being "reasonably accurate, reliable, sensitive to change in underlying policies and practices, and timely" (p. 336). Although Croghan et al. (2006) ultimately chooses "under five mortality rate" (U5MR) as a metric to rank overall children's health, the authors concede that an *ideal* health indicator very rarely exists in measurable reality. For the present study, the relationship between quantitative health indicators and governmental health policies is complex; a causal relationship between a specific policy and an indicator such as child mortality, life expectancy, maternal mortality, or immunization coverage would need to take into account the timing of the policy, the timing of the intervention, the time before an expected impact, the type of impact that would result, and other confounding variables. With that in mind, the focus here is on the leaders themselves and the decisions made on the national level of government that are geared toward healthcare, rather than the effects of policies on the population.

An economic analysis was initially attractive as the single tool for tracking healthcare as a priority over time, due to the theoretically consistent nature of the data. The World Bank defines a country's health budget as "the sum of public and private health expenditure… [that] covers the provision of health services (preventative and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation" (World Bank Data Indicators). A breakdown of public health allocations would reveal how much monetary attention the central government gave to each sector, and could offer a quantifiable view into the prioritization of MCH. However, Ke et al. (2011) explains that "there is often a belief that health expenditure has risen because governments and people continue to place a higher importance on health and healthcare, and as such, there is an increase in health care costs" (p. 7). Their study used panel data from 143 countries over 15 years to show that the main determining factors for health expenditure, in terms of its pure monetary value, are overall GDP and level of development. Therefore, changes in GDP allocations must not be seen as the sole measure of priorities, but rather one of the many ways in which the central government impacts healthcare.

Public investment in health is essentially a cost-benefit analysis: "ultimately, governments are forced, either implicitly or explicitly, to estimate the impacts of investments in different sectors to determine the opportunity costs or benefits per dollar invested" (Peabody et al. 1999). This is highly relevant when analyzing policy changes, because the cost-benefit analysis often drives the motivation behind choosing to prioritize one problem over another. For example, education and sanitation interventions have a large positive impact on MCH; however, the results may not be observed until generations after the policies are put into place. If

policymakers want to see immediate MCH results, they will most likely focus on a cost-effective, mass health campaign like immunization.

Income, education, and healthcare spending are imperfect indicators of health outcomes. Many countries spend relatively small amounts on health but have much better outcomes than countries that spend more and still have very poor life expectancy (Peabody et al. 1999). The implementation of government interventions is intended to shape the health sector in terms of "preventing or correcting failures in health-sector markets" and "ensuring equity when poor and vulnerable patients cannot afford health care" (Peabody et al. 1999). The primary way for the central government to do those things in terms of improving MCH is by providing a political climate for interventions to be passed, and supporting them with financial and political prioritization. These facts support the chosen method of the present study, which is to examine the national health policies of each case study.

### Selection of Maternal and Child Health Policies

In this study, national policies directed toward MCH were chosen for the purpose of examining an issue both gendered and universal in scope. In the literature and political discourse, MCH is considered a "women's issue" and can therefore be tested to determine whether substantive representation has occurred. At the same time, the impacts of MCH extend beyond women to the larger population, with repercussions that affect the health and well being of an entire society. The status of mothers and children as vulnerable portions of a population causes governments to implement specific laws and policies directed at issues that pertain to them in particular (Peabody et al. 1999). To answer the research question here, only national policy measures are considered. While local policies certainly affect MCH—and are often able to more effectively target the needs of vulnerable populations—existing research (see Background) has

already demonstrated the benefits of women's participation in local policymaking and lower-level legislative bodies.

In the Background, this paper illustrated many methods of involvement and intervention for MCH from the perspective of global health experts or lower-level policymakers. It is also important to examine the varied ways in which the central government can impact MCH, as it undoubtedly has unique power and resources that are essential for citizens to receive all types of health care. While the ideological role of government in health is highly debated, broadly speaking the national government is in charge of the budget and the structure of the country's health system. Planning and management, in terms of hospitals, health centers, clinics, personnel, and resources, are rooted in government allocations (Roemer and Roemer 1990). The countries chosen for this analysis all lay out centralized planning in terms of successive "Five Year Plans". These are essentially development plans and are therefore highly economic in nature, as they propose the amount of funding that should be allocated toward each sector of the government. The prime minister is in charge of approving the plans, and works with the Planning Commission to develop each one. Various ministries, such as finance, industry, and health, are key players in carrying out each plan (Rosen 1996). The Plans themselves are far-reaching, and include provisions for all sectors of the public: land and agriculture, animal husbandry and fisheries, communications and broadcasting, immigration, health, housing, labor, transport, research, education, and foreign exchange. To a certain extent, each Five Year Plan attempts to learn from the mistakes of the previous Plans and to adapt to the ever-changing nature of society.

I read the Five Year Plans of each country from the time of independence (when the Plans were instituted as the primary means of centralized policymaking) to the end of a woman prime minister's last term. The Plans of India and Pakistan were accessed through government

websites. Since the Plans of Bangladesh are not published electronically, it was necessary to order governmental or economic sources that cited copious amounts of each Plan. In addition to collecting primary data for the analysis, secondary accounts of the policies of each country added to the results by offering perspectives on the political context within which each Plan was formed. Often this secondary research examined the Plans through a single lens, such as health or family planning, which helped synthesize a large portion of data into relevant results.

There are other methods for governments to influence MCH that do not represent as strong of a political prioritization as national policies, but are still axial for progress. For example, cooperation with NGOs and increased funding for research on MCH problems were important for developments in global health as the twentieth century progressed, and are especially vital tools now. Within the scope of this study, cooperation with NGOs and increased research on MCH problems will not be considered. The international system itself, through agents like the World Bank, the World Health Organization (WHO), and the United Nations (UN), has also succeeded in impacting MCH as well as other large-scale public health problems in many developing countries. These organizations use political and economic pressure to ensure that their global agendas are accepted by many different countries. The priorities of these organizations are not always indicative of national priorities, which further points to the national Five Year Plans as the best method for analyzing the case studies.

## Case Study Analysis

### Ranking Policies

A system of rankings was established to track the changes and consistencies in the MCH policies of each case study. The ranks represent 3 levels of direct prioritization for MCH that can be expressed in a clear and objective manner. A government that does not clarify an intention to

improve MCH or institute programs for the betterment of MCH characterizes a ranking of 1. This means no words, no action. A government that *either* makes it clear that MCH is a priority *or* that institutes special programs for the betterment of MCH characterizes a ranking of 2. This means either words or action, but not both. A government that emphasizes the importance of MCH *and* implements direct policies to target MCH problems characterizes a ranking of 3. This would be indicative of a government that is using words and actions together to fully prioritize MCH. Rankings will be initially noted in the beginning of each description of case study results, and then reiterated every time an administration makes a change in policy that reflects a change in ranking.

### Determining a Baseline

For each respective case study, it was necessary to determine the government's approach toward MCH before a woman prime minister took office as a basis for measuring changes or consistencies. Choosing any man who served as prime minister with whom to conduct a direct comparison would be arbitrary, as there have been many diverse candidates in this position of power. Therefore, a trajectory of policies will be synthesized into a brief description of the "status quo" of MCH policies within each country. This trajectory will not be comprehensive, and some generalizations will be made with respect to each case study's historical relationship with MCH policies. Special attention will be paid to the years directly preceding each woman's first term in office, for the purpose of determining whether trends exist among the political climates of countries prior to electing a woman as prime minister. In the case that a woman enters office and immediately cancels the programs of her predecessor, a close examination of that timeframe is also important for acknowledging immediate changes that may occur once a woman takes office.

Because MCH falls into the category of a gendered issue, the baseline policy must to some degree demonstrate how gender functions in national politics. Therefore, a secondary analysis of the central government's policies and attitudes toward gender-related issues will be briefly summarized. As previously discussed, systems such as education and sanitation have two-fold significance in this study: they represent issues that have been gendered within political discourse and policymaking, and they are indirect influencers of MCH. Therefore, policies regarding education and sanitation will also be tracked at a basic level of analysis to further deepen the results.

Colonialism is a factor that deeply impacted each case study in terms of healthcare, national infrastructure, and economic and social development; however, the many far-reaching impacts of British rule cannot be fully explained within the confines of this study. It must be noted that during the post-WWII era, after the establishment of the WHO and the UN, and with the mass decolonization occurring all over the world, the approach to public health shifted from one of scattered epidemic prevention to one of active government responsibility (Amrith 2006). As the UN constitution promulgates, health is a fundamental and universal human right (United Nations 1948). The intersection of decolonization and health as a human right was manifested in the policies chosen for this analysis; burgeoning post-colonial states turned the pressures to provide health for all citizens into a nationalist perspective that new, independent governments would provide better care for their citizens than any colonial power ever could (Amrith 2006). Considering the push for active government health policies at that time, the search for data to inform the baseline political approach toward MCH commences with each country's independence. Even if the woman prime minister took office many years after independence, it is still important to observe the trajectory of how health policies changed over time.

## Effects of a Woman Prime Minister

The analysis of each woman prime minister will begin with an overview of her political background. The formal role of a prime minister is to act as head of the executive branch, chair of the cabinet, and leader of the party he or she represents. Within each woman leader's tenure as prime minister, specific policies that brought MCH to the forefront of national politics will be tracked. These policies must have been enacted at the national level. Secondary analysis will consider the prioritization of other gender issues; similar to the baseline policy analysis, attitudes regarding gender itself and policies on gender-related issues are crucial to answer the question of substantive representation.

Although each woman prime minister served nonconsecutive terms, this analysis will consider the entire expanse of time spent in office regardless of how many terms this encompasses. Continuing policy change most likely occurred in the interim period of nonconsecutive terms; however, the scope of this paper does not allow a thorough examination into that time frame. It was more important for the research to focus on the expanse of a woman prime minister and get a full picture of her priorities than account for intermittent regime changes.

In analyzing the baseline policies as well as any changes that women prime ministers put into place, it is important to note that the goal of this study is not to focus on the effectiveness, endurance, or expansiveness of the respective policies. Rodgers et al. (2006) reviewed the work of others and found that "an effective population-wide intervention draws together different kinds of feasible activities that combined produce a synergistic effect" (p. 856). The multivariate and subjective nature of deeming a policy "effective" reinforces the reason for focusing on political *attention* toward MCH, rather than actual results of the policies. Additionally, the

unique and historic context of each case study makes any value assessment of its policies mostly infeasible, because there is no consistent standard to which the policies can be held. Finally, global health is an ever-changing field, and the developments that occurred over the past half-century with respect to treatment, prevention, and monitoring of illness are not covered in this analysis.

It is widely accepted by political scientists and sociologists alike that political parties, social movements, and interest groups have an impact on the government and its policies. Burstein and Linton (2002) explain that empirical evidence has yet to determine a metric to understand the relative impact of political organizations on government policies. Scholars mainly ground their assumptions in the fact that all modern, democratic systems of government include such organizations; thus, research on these systems continues to feed into the thought process that political organizations are important, without measuring the actual importance. In a review of 53 articles from the disciplines of political science and sociology, Burstein and Linton (2002) set out to find "a measure of the relationship between the activities or resources of an organization, and a policy outcome" (p 389). Their findings show that political organizations, *assumed* to consistently and strongly influence policy, only do so about half the time. They conclude that the impact of organizations is overestimated and misrepresented in scholarship, which is not conducive to a nuanced view of political contexts and policymaking. Also, the types of policies that these organizations influence, and how they do so, have not been sufficiently studied. Party politics will not be considered in this analysis, as there was no indication from the literature to show that prioritization of MCH in these contexts were considered a partisan issue.

## Comparing Data Across Cases

In order to test the null hypothesis, trends across India, Pakistan, and Bangladesh were analyzed. To compare the policies of each woman prime minister, a visual side-by-side list of policies that begins with those most pertinent to MCH was constructed. Two metrics were used to determine trends in policies: (a) the issue that the policy aims to address, and (b) the manner in which it is designed to do so. A discussion of big picture themes and patterns follows the chart, using the two metrics to draw conclusions.

The Five Year Plans of India and Pakistan can be found electronically on government websites, and presented an opportunity to search for and track specific terms within each Plan. To code for attention toward MCH within each Five Year Plan, the words "child", "mother", "girl", and "matern" were tracked to see how many times they appeared. The word "mother" also includes "mothers" (but not mentions of "mother-tongue", "mother-ship" or "chemotherapy"), "matern" includes both "maternal" and "maternity", "child" also includes "children, and "girl" also includes "girls". These terms were chosen after initially reading the Plans for content, because they consistently cropped up in sections directly relevant to the analysis, such as health, education, and family planning, as well as in sections with an indirect impact on MCH, such as housing, labor policy, and scientific research. Bangladesh does not offer electronic resources of government publications and so this type of analysis was not possible for Bangladesh.

The number of times each term was mentioned throughout the Plans was not enough to measure prioritization; more important are the sectors of the Plans within which each term was found. For example, if a Plan mentioned "child" many times, but only within the section on education, there is little evidence to show direct attention to MCH. Repeated mentions of the

coded terms across multiple sections would confront the vicious cycles of poor health and the intersectional social determinants of health in which governments can intervene.

# Chapter 3: Results

## India

### Baseline Health and Gender Policy Findings

India addresses national policies through successive "Five Year Plans" issued by the central government. A few objectives have remained throughout all of India's development planning: rapid economic growth, removal of poverty, reduction of economic inequalities, regional balanced development, national self-reliance, and employment generation (Pandya 2009). The emphasis on various objectives as well as the tools put into place in order to achieve them change from Plan to Plan.

Health policies in India historically have mentioned MCH problems as a major challenge of the country, and acknowledged mothers and children as the most vulnerable portions of the population (Misra et al. 2003). However, beginning with independence and nationalized healthcare, mentions of MCH in India nearly always follow a discussion of family planning, as India's population has grown at enormous rates since independence in 1947. Family planning has consistently been directed at fertility reduction, with an indirect but explicitly stated goal of reducing infant and maternal mortality (Misra et al. 2003).

The First Five Year Plan, launched in 1951, set a precedent by including MCH services in the national agenda (Nair et al. 2000). Explaining how "the protection of the health of the expectant mother and her child is of the utmost importance for building a sound and healthy

nation" (Planning Commission of India), the Plan goes on to outline recommendations such as an increase in trained health personnel and health centers in rural areas. Family planning and nutrition were both largely separate from MCH in this first Plan. It is clear that since this was the new government's first real opportunity for nationwide policymaking, many of the country's problems were addressed in a broad manner, rather than via achieving highly specific individual goals. *Although the Indian government was in its formative years, it started off by directly articulating the importance of MCH. Since no targeted programs were initiated at this time, the prioritization began at level 2.*

The primary goal of the Second Five Year Plan, launched in 1956, was to expand the infrastructure of India laid out by the previous Plan. The health objectives of the Second Plan were (Pandya 2009, p. 102):

1. "Establishment of institutional facilities to serve as bases from which services can be rendered to the people both locally and in surrounding territories.
2. Development of technical manpower through appropriate training programmes and employment of person trained.
3. As the first step in the improvement of public health, institution of measures to control communicable diseases which may be widely prevalent in a community.
4. An active campaign for environmental hygiene.
5. Family planning and other supporting programmes for raising the standard of health of the people."

Each objective has an indirect impact on MCH. For example, better facilities and delivery of care help mothers and children to get treated in a timely manner, trained health workers prevent many maternal deaths during childbirth, control of communicable diseases (like malaria and

pneumonia) lessen the severity of outcomes from other illnesses, and improved hygiene decreases the risk of DD in children. However, the lack of direct emphasis on the importance of MCH makes it unclear whether MCH was truly a priority when developing these objectives. In terms of direct MCH attention, the Plan called for improvements in pediatric care, classifying pediatrics as the "weakest link in maternal and child health services" (Pandya 2009, p. 118). However, this was not a primary goal of the Plan. The overall focus was on expanding the infrastructure and existing heath services laid out by the previous Plan, as well as making progressive improvements and raising the standards of national health.

The Third Five Year Plan, effective from 1961 to 1966, covered the period before India's first woman prime minister took office. The specific goals of this Plan are highly concentrated on economic growth (Amundson 1964, p. 91):

1. "To secure a rise in national income over 5% per year.
2. To achieve self-sufficiency in food grains, and to increase agricultural production to meet the requirements of industry and exports.
3. To expand the basic industries like steel, fuel and power, and to establish machine building capacity.
4. To utilize to the fullest extent the manpower resources of the country and to ensure a substantial expansion in employment opportunities.
5. To bring about a reduction of inequalities in income and wealth and a more even distribution of economic power."

In line with prioritizing economic growth through various channels, Misra et al. (2003) noted that "successive Five Year Plan documents have enunciated a strong MCH component, but from the Third Five Year Plan period, the overriding focus has been population control" (p. 123). The

biggest change articulated in terms of health care in this Plan was a 397% increase in the number of family planning centers across the country (Amundson 1964). Family planning was given particular importance due to the economic consequences of overpopulation; of the 31% increase in national income laid out as a goal of this Plan, it was estimated that 12% of that would be absorbed by population growth, meaning that per capita income would only increase by 17%. Therefore, for the government to reach its economic goals, it was necessary to take into account an exponentially growing population, and the mitigating effects on economic progress that come with it.

In keeping with previous plans, the Third Plan sought to expand programs in sanitation, communicable disease, public health services, and training health personnel. These improvements would indirectly also improve MCH. In terms of social development, the Third Plan placed great importance on the expansion of education, as it called for "the expansion of all educational facilities" and "the initiation of free and compulsory primary education in the country for the age group 6 to 11 years" (Amundson 1964, p. 96). The Plan also addressed gender in the context of education, discussing the options of more women in the teaching vocation and somehow encouraging parents to send their daughters to school, although no specific means of achieving those goals were outlined.

### Policies of a Woman Prime Minister

India's first and only woman Prime Minister was Indira Gandhi, a member of the Indian National Congress (INC) party. She served two nonconsecutive terms: from 1966 to 1977, and again from 1980 to 1984. Gandhi was exposed to politics from a young age, as she was the only child of the first Prime Minister of India, Jawaharlal Nehru, who served from 1947 to 1964. An aristocrat, Gandhi grew up in a large family estate isolated from most of India. There, she

learned from tutors until her mother grew ill in Europe and she continued her studies at Oxford. Back in India, she served as Chief of Staff under her father's administration throughout his tenure as Prime Minister. After her father's death, Gandhi became president of the INC party, and was appointed to head the Ministry of Information and Broadcasting by her father's successor, Prime Minister Lal Bahadur Shastri. After Shastri's death in 1966, Gandhi was appointed to the office of prime minister until the following year, and was officially elected in 1967.

As soon as Gandhi took office, she and the Planning Commission drafted the Fourth Five Year Plan. However, events that had recently transpired in the country, including hostilities with Pakistan, two successive droughts, and economic woes caused a disruption in normal planning. Instead, Gandhi cancelled the Fourth Plan and implemented three Annual Plans, which were better suited to address the immediate and emergent needs of the country. Aside from economic improvement, population health was given the greatest priority in each of the Plans. The First Annual Plan gave extremely high priority to family planning, and also increased funding for malaria, smallpox, and trachoma eradication. The primary tools for promoting smaller families in this time were programs for education, contraceptives, and sterilization (Pandya 2009). Upon reviewing the progress made in that year, it became clear that the national programs for eradicating malaria, smallpox, and trachoma were successful, but the rate of fertility decrease was not happening quickly enough to meet the goals. The Second and Third Annual Plans put enormous resources into family planning programs, and continued to expand existing public health infrastructure.

Gandhi reinstated the Fourth Five Year Plan in 1969 with the opportunity to clearly define the agenda for India's development and progress. Gandhi's main focus for economic

improvement with this Plan was advancements in agriculture and increased national production of goods and exports. Her attention toward rural populations was also reflected in the main healthcare priority of this Plan: “During the Fourth Plan, efforts will be made to provide an effective base for health services in rural areas by strengthening the primary health centres” (Planning Commission of India). Expanding on the previous Plan, Gandhi continued to integrate MCH services within family planning.

> The scheme of immunisation of infants and pre-school children with DPT, immunisation of expectant mothers against tetanus, prophylaxis against nutritional anaemia for mothers and children and nutritional programme for control of blindness caused by Vitamin 'A' deficiency among children will be implemented through family welfare planning centres. Family planning will be effectively integrated with the general health services of primary health centres and sub-centres. (Planning Commission of India)

By explicitly listing the causes of poor health and proper interventions, Gandhi also increased the specific mechanisms for improving MCH.

As previously stated, governments preceding Gandhi have consistently addressed the issue of overpopulation in India. However, a clear ideological shift with MCH implications took place in attitudes toward remedying the situation under her leadership. “During the late sixties the Government of India realized that… unless proper care was given to [the] mother and child health, the people in general would not accept the small family norm” (Sinha 1995, pp. 37-38). The existing thought process was essentially that unless parents could be more confident that their children would survive into adolescence, they would continue to reproduce as a measure of insurance. This served to exacerbate the problem of overpopulation and led the government to take more drastic action toward MCH. An important change that occurred under this Plan was

the establishment of a program to directly prioritize child and maternal nutrition. "The Special Nutrition Programme was introduced in 1970-71 as a crash scheme to provide 300 calories with 10-12 grams of protein for the age group 0-6 years for 300 days in a year. It also provides 500 calories with 25 grams of protein for pregnant women and nursing mothers for 300 days" (Pandya 2009, p. 166). Setting these standards was especially important given the many illiterate or uneducated women of childbearing age. With a crash scheme like the Special Nutrition Programme, vulnerable portions of the population were provided with tangible ways to become healthier. *Because the language of this Plan is primarily geared toward family planning, the implementation of a program directed at MCH maintains the prioritization at level 2.*

Gandhi's prioritization of family planning must also be viewed through the lens of sterilization programs within the Fourth Plan. The Fourth Plan was unique in setting a numerical goal for slowing population growth: to "reduce the birth rate from 40 per thousand at present to 25 per thousand as expeditiously as possible" (Planning Commission of India). The ideological shift to small family norms along with the increased attention toward educating women have been mentioned as two important ways for this government to decrease population growth; however, in terms of the "quick fix" mentality, Gandhi was very committed to sterilization programs throughout the country. In the early 1970s, this was mainly achieved through the establishment of mass vasectomy camps (Krishnaraj 1998).

In 1974, during a period of economic distress in India, Gandhi developed the Fifth Five Year Plan. This Plan took a hardline approach toward the idea of poverty alleviation and the minimum needs of the people by outlining a strategy to further integrate family planning with MCH and nutrition, as well as increasing the tempo of population policies. There was also a heavy focus on strengthening the previous programs to eliminate key communicable diseases,

and to ensure an adequate number of health personnel in curative, preventive, and promotive health services (Pandya 2009).

In the first year of the Fifth Plan, Gandhi introduced the Minimum Needs Programme, which incorporated her hardline approach to poverty alleviation with targeting health through other routes of development (Nair et al. 2000). The first objective was that facilities should be provided to those areas that are most in need, thereby attempting to close the gap in health disparities between rural and urban residents. This again reiterated the priorities of Gandhi's government by effectively expanding and strengthening health infrastructure in rural areas, including direct support for MCH. The second objective was that these services should be provided as a "package" of sorts,in order to have a greater impact on a wider populace, and adding nutrition to the agenda was an important way of achieving that goal. Until now, Plans had not explicitly prioritized nutrition to such an extent. This program had provisions for producing and fortifying nutritious foods, nutrition education through mass media, and expanding feeding programs for vulnerable populations (Mid-Day Meals Programme for school-aged children, Special Nutrition Program for children under age 6 and expecting mothers). *Here, the government of India under Indira Gandhi directly prioritized MCH, and instituted programs targeted at the betterment of MCH, raising the level of prioritization to 3.*

In 1975, Indira Gandhi urged the President of India, Fakhruddin Ali Ahmed, to announce a national state of emergency. Her reasons were primarily grounded in the collapse of the economy and the political system, stemming from a war with Pakistan, the ongoing oil crisis, nationwide strikes and protest, and accusations of using fraud to help her win the 1971 election. From 1975 to 1977, the government enacted a state of emergency, effectively suspending elections and giving Gandhi the power to rule by decree. Health and family planning during the

state of emergency was almost entirely focused on sterilization, mainly through vasectomies. This policy (headed by Gandhi's son Sanjay) remains very controversial, as many believe that it employed coercive tactics in order to achieve results. Indira Gandhi's autocratic rule in this time frame also remains controversial. No other relevant health policies were put into place during the state of emergency. Once the state of emergency was released, normal elections resumed and Gandhi failed to be reelected in 1977.

After an interim period of 3 years, Gandhi was reelected for her second term in 1980. When she was reelected for a second term in 1980, Gandhi terminated the other government's Sixth Year Plan and launched her own, widely considered to be India's most successful. This Plan's primary focus was an attack on poverty, and its main health objectives were continuing the extension of care to rural areas, increasing the number of trained health workers, and controlling and eliminating multiple communicable diseases (Pandya 2009). Like many prior Plans, family planning was given highest priority. Gandhi's Sixth Plan realized that previous attempts at family planning, while prioritized within the government, did not achieve sufficient results in the population. Therefore, new objectives for family planning were laid out (Pandya 2009, pp. 186-187):

1. "Average size of the family would be reduced from 4.2 children to 2.3 children.
2. Birth rate per thousand population would be reduced from the level of 33 in 1978 to 21.
3. Death rate per thousand population would be reduced from about 14 in 1978 to 9 and the infant mortality rate would be reduced from 129 to 60 or less.
4. As against 22 percent of the eligible couples protected with family planning at present 60 percent would be protected.

5. Population of India will be around 900 million by the turn of the century and will stabilise at 1,200 million by the year 2050."

Essentially, the previous Plans failed to decrease population growth because the greater public refused to accept the small family norm. Upon realizing this, Gandhi's government set out on "the total national effort for providing a better life to the people… through specific programmes directed towards the target groups such as small and marginal farmers, rural artisans, landless labourers, women, scheduled [disadvantaged] castes and scheduled [disadvantaged] tribes etc" (Pandya 2009). The Plan also explicitly stated that it would avoid coercive methods of family planning, presumably because Gandhi came under harsh criticism for the sterilization campaigns of previous Plans. The Sixth Plan's push for positive improvement and incentives for family planning place programs directed towards women were of utmost importance. The major direct methods of MCH improvement were immunization, supplementary nutrition, prophylaxis, and environmental sanitation to prevent diarrheal disorders, and a major indirect method was school health education so children would learn the best practices of health.

After evaluating the nutrition policy of Gandhi's Fourth Plan, many changes were put into place in the Sixth Plan. Namely, the focus of nutritional betterment was expanded from just the mother and the child to that of the entire population. The government realized that employment and economic empowerment is the most effective way of increasing nutritional status, so they linked poverty reduction with nutritional programming. Still, children remain a large focus of nutrition through education programs, with the content focused on "the relationship between nutrition and health, pregnancy, birth rate, immunisation, drinking water, environmental and personal hygiene, eradication of helminthes and other intestinal parasites" (Pandya 2009, p. 188). Additionally, the Special Nutrition Programme (providing supplements to

young children and pregnant women) and the Mid-Day Meals Programme, both having been initiated in Gandhi's Fourth Plan, were to be expanded and continued.

In 1983, Gandhi's government formulated and endorsed the National Health Policy (NHP) of India. It reiterated the "unacceptably high" rates of infant mortality, maternal mortality, and many other disease burdens. The overarching message of the NHP was a reaffirmation of the need for universal comprehensive care through networks of primary care facilities, skilled health practitioners, and updated technology (Planning Commission of India). There was not an overwhelming focus on MCH, but mothers and children were mentioned in reference to holding the burden of poor nutrition. Gender was also dealt with in terms of the interconnected risk factors and determinants of poor MCH.

## Pakistan

### Baseline Health and Gender Policy Findings

Similarly to India, Pakistan creates policy goals on the national level through successive Five Year Plans, and at present they are widely considered a powerful policy instrument for setting national priorities (Siddiqi et al. 2004). In contrast, the First Five Year Plan, which was presented to Parliament in 1948 (a few months after independence), failed on many grounds and had to be dissolved by the Prime Minister in 1953. In 1955, another First Five Year Plan was attempted, consisting mostly of grants to private family planning groups, and was largely ineffective at its goal of reducing the fertility rate (Robinson 1966). The Plan primarily addressed MCH as a "by-product" of the projected development gains (Planning Commission of Pakistan). After calling for more trained health personnel and health centers, the majority of the references to MCH referred to the anticipation that better nutrition, housing, and knowledge about health

would come out of economic improvement. *Nothing directly called for the prioritization of MCH, which means that the government of Pakistan started at level 1.*

The Second Five Year Plan, launched in 1960, explicitly defined family planning as the main priority (Planning Commission of Pakistan). After noting the failures of the First Plan, a different method of reducing population growth was considered; "the Second Plan health programme [was] primarily designed to influence social attitudes and practices in favour of family planning" (Robinson 1966, p. 257). In addition, an expansion of clinics and medical facilities, training of health workers, and updating of education programs were prioritized. Neither of the first two Plans prioritized MCH directly, and while overall health was mentioned, thus far they were primarily focused on rapid economic growth through investment in the private sector. An important and lasting achievement from this Plan was the implementation of a malaria eliminating program. In accordance with the general view of health in this time, much of the resources for eliminating malaria were coordinated with the private sector and outside organizations.

The Third Five Year Plan, from 1965 to 1970, aimed to lower the birth rate from 55 per thousand to 45 per thousand. The tools that the government provided to accomplish this were mainly monetary incentives. Contraception was subsidized, health practitioners made commission on each vasectomy performed, and insertion of IUDs were free for clients. The Pakistani government made a point of noting that "more than in any other country, the monetary incentives are being assigned a significant role in the programme of family planning" (Stamper 1973). The only explicit mention of MCH in this Plan was: "The future policy is to provide for maternity and child health services as part of the general health services and not in separate maternity and child health centres. Accordingly, there is no special provision for maternity and

child health services in the Third Plan, except for the frontier regions and the special areas" (Planning Commission of Pakistan). This not only shows that MCH took a backseat to the government's focus on family planning, but also that the government recognized the importance of MCH and intended to manage it more directly in the future.

The Fourth Five Year Plan period, from 1971 to 1976, was also known as the "No Plan Period". Initially, a Plan was laid out and approved, but due to the bloody war with India, and the aftermath of East Pakistani (Bangladeshi) independence, it was effectively ignored. The provisions laid out for MCH in this Plan had been small, as the only mention was an objective "to provide special health care to infants, children, adolescents and mothers and the handicapped with particular attention to reducing infant and maternal mortality through comprehensive health care" (Planning Commission of Pakistan). The methods of achieving that goal are not specified.

It must be noted that from 1977 to 1985, Pakistan was placed under strict Martial Law by General Zia-ul-Haq. He staged a coup d'état to dissolve the previous government, and had the former Prime Minister executed in order to proceed with his own agenda of Islamizing and militarizing the state. Under General Zia-ul-Haq, strict regulations were imposed on the separation of men and women in society.

> The combination of (1) the implementation of an Islamic penal code wherein punishments were meted out in a highly discriminatory fashion; (2) the issue of evidence given by a woman as possibly not being equal to that given by a man; and (3) the proposed law of Qisas (retaliation) and Diyat (blood money) that would have allowed payment to the family of a murdered woman to be only half that paid if the victim is a man, all combine into an ideological perspective that does not perceive women as equal in value to men. (Weiss 1990, p. 439)

This regime also separated men and women in schools and colleges, and any improvements to female literacy were ignored (Weiss 1990).

The primary focus of the Fifth Five Year Plan, which took place within General Zia's regime in 1978, was increasing agricultural production through the development of the rural sector (Bjorkman 1986). Specifically, the aims of "development" included an expansion of health centers, reduction of the crude death rate and infant mortality rate, increase in life expectancy, and a modernization of current health facilities (Bjorkman 1986). The objectives for achieving this goal included social services to improve health, clean drinking water, and schooling for children in rural areas. Although child health was prioritized, maternal health was effectively not mentioned in this Plan. "This attitude which divided basic, essential healthcare into separate components as national policy, prioritising one while neglecting the other, wreaked untold havoc in women's lives" (Saeed 1999). The lack of MCH prioritization, as well as the absence of programs geared toward sanitation and education, shows that Zia's government did not realize or act upon the interconnected determinants of health.

The Sixth five Year Plan, launched in 1983 (as General Zia's reign was nearing its end), represented a shift in the national government's outlook on gender. "For the first time after nearly three decades of development, planning explicitly considered policies for integrat[ing] women in the development process and emphasized the need for strengthening employment opportunities for women" (Kazi et al. 1992, p. 610). This Plan placed a heavy emphasis on preventative care through immunization, DD control, and improved maternal care (Bjorkman 1986). *Although no specific measures of MCH improvement were outlined, the importance of MCH that was emphasized in this Plan raised the level of prioritization to 2.*

## Policies of a Woman Prime Minister

Pakistan's first and only women Prime Minister was Benazir Bhutto, a member of the Pakistan People's Party (PPP). She served two nonconsecutive terms: from 1988 to 1990, and again from 1993 to 1996. Bhutto was born into a political family, as her father was Prime Minister for four years and President for two years. Bhutto was educated well in Pakistan, and further pursued her higher education at Radcliffe College and Oxford. Her father was overthrown from his position as Prime Minister in General Zia-ul-Haq's coup in 1977, and he was tried and executed by the Pakistani Supreme Court in 1979. Bhutto formally entered politics after six years in house arrest and imprisonment, which was imposed on her by the military regime that had overthrown her father. She ran for party leader while in exile, and was only able to return upon the death of General Zia. When Bhutto led her party to victory in 1988, there was initial doubt as to whether a woman could actually serve as prime minister in a Muslim country under Shari'a law. A religious pronouncement (fatwa) was declared that because she was not President, or "head of state", but rather a national party leader, she could indeed carry out her position. She was the first woman to hold the title of Prime Minister in a Muslim country.

Prior to her victory in 1988, Bhutto released the People's Party Manifesto, which enumerated seven ways in which the PPP would "eliminate all forms of discrimination against women" (Weiss 1990). Ranging from promoting women's literacy to repealing all discriminatory laws against women, the theme of women's empowerment was clear in the PPP's campaign and helped ensure their victory. None of the seven pledges addressed issues of MCH directly (Weiss 1990, p. 434):

1. "Sign the [United Nations] convention on the Elimination of all forms of Discrimination against Women;

2. Actively support women's right to work, to free choice of employment, to just and favorable conditions of work, to protection against unemployment, to equal pay for work of equal value, and payment of maternity leave;
3. Repeal all discriminatory laws against women;
4. Reform Personal Law and bring it in line with the demands of contemporary socioeconomic realities;
5. Ensure that the law-enforcing machinery would be made effective to protect [the] modesty of women;
6. Take special measures to promote the literacy of women; and that
7. Jahez [dowry] would be eradicated by enlarging social consciousness and strictly enforcing the relevant laws and Dowry Act."

During Bhutto's first term it became clear that bridging the gap between her polarized constituents—the poor, disenfranchised, women and minorities versus the wealthy, loyal party members—would be challenging at best. Furthermore the economy was weak, and the opposition party that had just been defeated by the PPP still remained powerful and vocal in Parliament. In attempts to make good on her promises from the Manifesto without simultaneously alienating parliamentarians who were less enthusiastic on the issue, Bhutto upgraded the Women's Division of the government to the Ministry of Women's Development in 1989 (Weiss 1990). With its new status as Ministry, this entity had the opportunity to enact laws and policies geared toward the goal of improving women's status in the country. The Ministry of Women's Development formed other committees for women's needs, which showed a commitment to "the uplift of women" by pulling them into decision-making power positions (Weiss 1990). That same year, Bhutto created the "Women's Bank" in order to facilitate

economic empowerment. This was later praised as "the first tangible and meaningful step toward recognizing the Pakistani woman as an independent economic entity" (Weiss 2009, p. 444).

Benazir Bhutto's government created the Seventh Five Year Plan in 1988 with the aim of improving the country's economy by learning from past mistakes. This Plan was consistent with the previous one in terms of "integration of women in development through the provision of equality of opportunity in education, health and employment and all other spheres of national life" (Kazi et al. 1992, p. 610). However, it differed in that it provided more specific goals and action plans geared toward a broad array of policies to ensure women's empowerment. The Seventh Plan explicitly addressed MCH in its discussion of healthcare objectives:

> First, to collect and make available vital information relevant to the health and welfare of women and children so that problems are viewed in a proper perspective; second, to launch an effective and continuous health education programme for mothers, families, and community leaders, as an essential pre-requisite for community action; third, to establish a network of health services for women's health so that in the next five years each rural and urban community in all parts of the country is covered with an efficient health service; and fourth to launch special continuing programmes to combat the major challenges of malnutrition and disease among those groups of women and children identified as most vulnerable. (Planning Commission of Pakistan)

In comparison with the objectives of previous Plans, which often cover immunization, education, and nutrition, it is clear that Bhutto instituted additional alternative means of prioritizing MCH. These were highly specific goals that separated MCH from family planning, and showed government innovation in the prioritization of MCH.

Additionally, this Plan removed the previous regime's educational restrictions for girls, and sought to "replace it with a new value system which emphasizes equality, mutual respect and dignity among members of both sexes" (Planning Commission of Pakistan). Specifically, this Plan included provisions to increase girls' enrollment in primary school and provide girls with the opportunity to study the sciences and all subjects available for boys. Other relevant goals include staffing primary schools with women teachers, and filling about 50 percent of health professions with women over the next 20 years. While it did not meet all of its numeric targets, the actualization of the Seventh Plan was still a relative improvement: 16.8 million children were immunized against the target of 18.8 million, and about 43.3 million packets of ORS were distributed against the target of 50.4.

The Eighth Five Year Plan was launched in 1993, when Bhutto took office for her second term. The approach to this Plan represented somewhat of a paradigm shift in the government's outlook on development; rather than addressing only current problems, this Plan sought "a total transformation, so that Pakistan's polity can fulfill its appointed destiny in the more challenging world of the twenty first century" (Planning Commission of Pakistan). One of the ways in which Bhutto's government attempted to update health sector improvements—especially regarding MCH and family planning—was by incorporating an "evaluation module" that surveyed recipients of MCH and family planning services. Gauging civilian responses to the efficacy of healthcare programs came about from the realization that failures in meeting numeric goals of health improvements stemmed from a disconnect between the government's interventions and the people's needs (Saeed 1999).

This Plan also took initiated the Social Action Programme (SAP) that had been proposed in 1992 as a three-year initiative. Bhutto's government integrated the program into the national

agenda and lengthened it to fit the span of the Eighth Five Year Plan. SAP was created with five components: 1) basic education, 2) primary health, 3) nutrition, 4) population welfare, and 5) rural water supply and sanitation (Planning Commission). Much of the funding and management of SAP came from the World Bank, but the provisions were laid out in the Eighth Plan (LaPort 1996). Within the Eighth Plan, SAP gave the highest priority to education of girls, followed by the care of infants and unreached rural populations. SAP oversaw the implementation of a School Feeding Programme to incentivize girls in particular to attend school. It also took measures to improve "primary education, basic health, nutrition and availability of water and sanitation facilities" (Planning Commission of Pakistan). *The Eighth Plan's commitment to prioritizing MCH issues with both targeted programs as well as directly emphasizing the importance of MCH raises the prioritization level to 3.*

## Bangladesh

### Baseline Health and Gender Policy Findings

After a bloody war of liberation with Pakistan lasting nine months, Bangladesh gained independence in 1971. Until then, the health of the Bengali people was under the rule of Pakistan, often with special services provided to what was then West Pakistan. The new government of Bangladesh struggled to establish itself while also managing the aftereffects of the devastating cyclone of 1970, as well as a nationwide famine of 1973-1974. Similarly to the other case studies, overpopulation was another major concern of the new government. The First Five Year Plan, launched in 1973, set out to reduce population growth and "provide 'minimum' healthcare to the entire population with particular emphasis on the poor and disadvantaged" by setting up health infrastructure and training health personnel (Osman 2008, p. 264). Within this Plan, in 1976, the first official nationwide policy of population control was implemented. This

policy became the main tool used to achieved the First Plan, focusing on provisions for setting up health services and family planning services throughout the country, as well as employing female field workers and providing doorstep services to rural areas. From 1978 to 1980, there was an interim period between Plans that emphasized private investment and responsibility for providing health services. Public services were effectively not expanded during this time. *Without a specific mention or program directed at MCH, the government's prioritization of MCH began at level 1.*

The Second Five Year Plan, beginning in 1980, emphasized primary healthcare and cooperation with NGOs (Osman 2008). In this time frame, the government of Bangladesh instituted a Menstrual Regulation (MR) program in 1974 on a small scale, and by 1979 it was integrated into the national family planning movement. MR is a form of abortion that "involves evacuation of the uterus by vacuum aspiration within 6-10 weeks of a missed menstrual period" (Chowdhury and Moni 2004, p. 95). Although abortion is not technically legal in Bangladesh (except to save the mother's life), this practice is seen as a measure of "control" for women who are late on their menstrual cycle and it is often practiced without confirmation from a pregnancy test. This policy is still in place, and it is estimated that 5% of married women have had the procedure done at least once in their lifetimes, according to the Bangladesh Demographic and Health Survey of 1999-2000 (Chowdhury and Moni 2004). Due to the ideological component of abortion, especially in a religious, Muslim country, the goals of this intervention were somewhat ambiguous. It is inferred that the government sought this measure as an option to protect women from unsafe abortions, as well as to encourage smaller families. *Here, the government implemented a program to improve MCH without an articulation of the importance of MCH, raising the prioritization to level 2.*

The Third Five Year Plan represented a change in the way that MCH was approached by the central government; launched in 1985, this Plan explicitly focused on MCH as an "effective" means for population control (Osman 2008). In this regard, MCH was seen as a means to a more pressing end. It strengthened already existing policies, such as the Expanded Programme on Immunisation (EPI), Vitamin 'A' distribution, and control of diarrhea. The Fourth Five Year Plan, launched in 1990, followed suit in emphasizing MCH, but focused more on primary care as a means to that end.

### Policies of a Woman Prime Minister

Bangladesh's first female Prime Minister was Khaleda Zia ur-Rahman, a member of the Bangladesh National Party (BNP). She served two terms: from 1991 to 1996, and again from 2001 to 2006. After Benazir Bhutto, Zia was the second woman to become prime minister in a Muslim country. Zia does not come from a political background, and growing up she did not have a strong interest in politics (Mohiuddin 2008). This changed once she was married, as Zia is the widow of President Ziaur Rahman, who founded the BNP before he was assassinated in 1981. In 1982, the regime that overthrew Rahman imposed a military rule, which was strongly opposed by many other parties in the government. After facing such harsh opposition, the regime fell in 1990 and Zia was elected the following year.

Zia inherited the Fourth Five Year Plan when she took office in 1991, and it was effective until 1995. This Plan was almost entirely devoted to family planning. As MCH was still viewed by the government as a means to an end, there was continuing attention toward managing delivery of MCH services, namely through establishing more centers and clinics, in order to reach a broader public (Osman 2008).

Bangladesh presents an interesting case study because the first woman prime minister did not formulate any of the Five Year Plans, and therefore had limited opportunity to set the national agenda. Furthermore, Bangladesh has had two women in the position of prime minister, each representing a different party. After Khaleda Zia's first term, another woman named Sheik Hasina Wajed took office. Sheik Hasina is the leader of the Bangladesh Awami League (BAL), founded by her father who was the second Prime Minister and later the first President of Bangladesh. Unlike Zia, Hasina grew up immersed in politics from a young age (Mohiuddin 2008). In 1975, after her father was elected as President, he, her mother, and her three brothers were assassinated by military officers. After six years spent in exile, Hasina returned to Bangladesh in 1981, the same year that Zia's husband was assassinated. Although the current rivalry and personal vendetta between these two women is fierce and often ugly, at the time they came together under the united goal of bringing democracy back to Bangladesh, and they were both instrumental in ending the military rule (Mohiuddin 2008). Hasina served from 1996 to 2001, at which time Khaleda Zia won back the role of Prime Minister.

1995 to 1996 saw a great amount of political unrest in Bangladesh; Zia was initially reelected, but all other parties boycotted the ruling under the accusation that the BNP had rigged the election. The rest of parliament went on strike until another election was conducted under a caretaker government. In 1996, Hasina's party won the majority and she was elected for the first time.

In 1997, Hasina's government initiated the Health and Population Sector Strategy (HPSS) and created the Fifth Five Year Plan. The HPSS sought to reform the health sector for cost-effectiveness and increased efficiency (Osman 2008). Its primary aim was a "one-stop service delivery" for communities and districts to consolidate their resources and health provisions. The

Fifth Five Year Plan took most of its aims from the HPSS and coordinated many of the same provisions. The Fifth Plan also included an ideological component in its objective, admitting that the "disparity between women and men persists—in their access to education, health and nutrition, in their right to life and property and protection by their societies and legal systems" (Planning Commission of Bangladesh). Both the HPSS and the Fifth Plan introduced an Essential Services Package, which continued to consolidate resources while establishing the most basic needs of the people (Osman 2008).

In 1998, the methods for achieving the HPSS and the Fifth Plan were laid out in the Health and Population Sector Programme (HPSP). The HPSP was essentially an operational plan to "boost" the health sector with very specific management strategies (Osman 2002, pp. 265-266):

1. "A transition from a projectised bifurcated approach to sector-wide approach (SWAp) of management through which all the sectoral projects were planned and managed in an integrated manner instead of running vertical projects.
2. Unification of the health and family planning wings of the Ministry of Health and Family Welfare (MoHFW) to avoid duplication and overlapping of MCH services and to provide health and family planning services in a package to ensure efficiency gains.
3. To achieve the greatest health and impact per Taka spent and to serve the most vulnerable groups like women, children and poor, an Essential Service Package (ESP) containing five basic maternal, child and public health services was introduced which was delivered from one single service point, called 'one stop shopping'. The objective of introducing this was to make access easier to multiple health services for clients (for multiple family members, i.e., a mother and her young child or children) during a single health facility

visit. One-stop-services were provided in a three-tiered fixed facility, i.e., *Upazila* Health Complexes (UHCs) at the *upazila* (sub-district) level, the Union Health and Family Welfare Centres (UHFWCs) at the union level and community clinics at the village level. Bangladesh is administratively divided into 6 divisions, 64 districts, 481 *upazilas* (designated as *thana* till 1982) and 4,498 unions.

4. Construction of community clinics for every 6,000 population, which was an effort to take the healthcare service structure closer to the people at the grassroots."

The most crucial implications for MCH come from the second and third strategies. The second calls for a consolidation of operations, and its goal of streamlining the approach to improved MCH is especially important for child health; because young children, as dependents, cannot take themselves to a health center, this "one stop shop" increases the odds that children get essential care if/when they accompany their mothers. It essentially presents the option to tackle both maternal and child health policies in one visit. The ESP was expanded under the HPSP in the same vein, as emphasis was placed effectively on delivering basic care to the population through health centers (Osman 2002). *With these programs and an articulation of the special importance of MCH, the prioritization was raised to level 3.*

In the year 2000, Hasina approved the National Health Policy (NHP) of Bangladesh. This was significant in terms of the role of the government in health, as "the preamble of the policy document states that the provision of health for the people is the constitutional obligation of the state" (Rahman 2006). This policy essentially reiterated the goals of the HPSP and the Fifth Plan, and because it was established after said programs were already put into place, it maintained similar strategies (Osman 2008, p. 266):

1. "To reach basic health services to the people at all levels, particularly to the poor.

2. To ensure the availability of primary healthcare services at the union and *upazila* levels.
3. To improve maternal and child health and reproductive health services.
4. To strengthen family planning services."

The prioritization of MCH on the national level is clear, as one of the four NHP strategies directly influences MCH, while the other three have important indirect influences.

Khaleda Zia was reelected as Prime Minister in 2001. She entered into an unstable political climate, as there were many failures of the previous regime. In an effort to reestablish her goals and ideas, Zia's government adopted a "100 day program" to quickly improve the status of the country. This was primarily focused on decreasing crime and reinstating proper law and order, as corruption and misconduct had become prevalent in recent years (Islam 2005). Zia did not seek to implement a Sixth Plan at this time.

In 2003, Zia's government formed another program when the HPSP expired. This one, called the Health, Nutrition and Population Sector Programme (HNPSP) was to be in effect from 2003 to 2010. The biggest update to the HNPSP was the explicit incorporation of nutrition into its primary objectives. Additionally, this program had more provisions for marginalized people to receive adequate care "through pro-poor targeting measures" and by "subsidising the cost of drugs, tests, and transport to the health facility, since utilisation is greatly discouraged due to high out-of pocket spending for these purposes" (Osman 2008, pp. 268-269). Maternal health was especially targeted in that regard, as a voucher scheme for antenatal and birthing care (to be used at home, in public health centers or in private facilities) was implemented (Osman 2008). By calling the improvement of MCH a "necessity" rather than a priority or a goal, the HNSPS program stood out against previous programs that had prioritized MCH (Rahman 2006).

## Discussion

### Ranking Policies

Within each country, tracing the political prioritization of MCH over time yields interesting results. The ranking system shows that under men prime ministers, the level of prioritization did not surpass 2. In all cases, the level of prioritization under women prime ministers rose from 2 to 3.

In India, national health policies after independence and prior to Indira Gandhi's first term mentioned MCH, but did not mobilize the government to take action. Due to the repeated mentions of MCH in the initial Plans, the level of prioritization began at 2. When Gandhi took office, the government made a switch from prioritizing MCH via the verbiage of the Five Year Plans to prioritizing MCH with policies. However, because these policies were aimed at population control and fertility reduction, the level of prioritization remained at 2. With Gandhi's implementation of the Minimum Needs Programme, which also expanded the Special Nutrition Programme, it became clear that the government at that time prioritized MCH by emphasizing its importance as well as laying out provisions for specific interventions. Therefore, under Gandhi's leadership the level of prioritization was raised to 3.

In Pakistan, the national government was relatively ignorant toward MCH after independence, and thus their prioritization of MCH began at level 1. Only when the military rule over the country was coming to a close did policymakers attempt to incorporate women into the national agenda, and emphasized the importance of MCH. No specific programs were instituted, but the increased mentions of MCH in national planning raised the level of prioritization to 2, which occurred right before Benazir Bhutto took office. While Bhutto initially struggled to pass

her agenda, in the Seventh Five Year Plan she introduced new and innovative ways to improve MCH. In the Eighth Plan she nationalized the SAP, raising the level of prioritization to 3.

Bangladesh, which gained independence from Pakistan in 1971, also began its prioritization of MCH at level 1. The First Five Year Plan did not mention MCH in a real way, and the specific programs it put into place were all geared toward family planning. With the Second Plan, the national government instituted the MR program. By its very nature, MR represented a program to prioritize MCH without verbalizing the importance of safe abortions, earning it a ranking of 2. The Fifth Year Plan period under Sheikh Hasina's government raised the prioritization level to 3, by implementing national programs to target MCH, including the HPSS and the Essential Services Package. The tenures of each woman prime minister of Bangladesh saw continuous and sustained prioritization of MCH at level 3.

### Comparison of Women Prime Ministers

The two metrics under consideration in the cross-country comparison are (a) the issues confronted in each policy, and (b) the manner in which the policy was implemented (see Methods). There are clear trends of women prime ministers confronting nutrition as a major health problem. Both Gandhi and Bhutto addressed the issue of nutrition more directly than their predecessors—Gandhi by creating the Special Nutrition Programme (1970-71) and Minimum Needs Programme, and Bhutto by attaching "nutrition" to the "health" chapter of the Seventh Year Plan, as well as nationalizing and lengthening the SAP in the Eighth Plan. In Bangladesh, the HPSS and HPSP were initiated under women prime ministers and both dealt with nutrition as special national programs. Khaleda Zia later created the HNSPS, reiterating the importance and strengthening the prioritization of nutrition by adding it to the title of the nationwide intervention.

In terms of the overarching goals of the policies, there was a strong emphasis on strengthening delivery systems of health, especially to rural residents. In particular, Gandhi's Fourth Plan included rural health as a main priority, and her Minimum Needs Programme sought to reach people who were not getting basic healthcare. In her Seventh Plan Bhutto sought to establish a network of health services for women across the country, and the SAP in the Eighth Plan targeted care for infants in rural populations. Specific provisions for "family welfare centers" to be established in every village were included throughout the HPSS, HPSP, and HNPSP of Bangladesh. All of the women prime ministers pushed for more health centers and more trained health workers in rural areas, which are known to have an important impact on MCH (see Background).

The manner in which women prime ministers directed attention toward MCH followed similar tracks, and largely involved family planning. All of the countries faced problems of overpopulation, and the governments began forming policies to mitigate those problems beginning with independence. At a certain point in the trajectory of Five Year Plans, family planning services were integrated with other health services. In India, this happened under Indira Gandhi, when the government realized that family planning alone could not tackle overpopulation, and that the health of children and newborns played a large role in the size of the family. In Pakistan, Bhutto's Seventh Plan was the first to integrate MCH with family planning services. Before a woman took office in Bangladesh, the government's Third and Fourth Five Year Plans began to prioritize MCH on a level of importance equal to family planning. At this point, it must be considered whether there is a gender trajectory of MCH policies that many countries with severe overpopulation and MCH problems naturally follow.

The policies under women prime ministers after this trend of "integration" are telling. Once MCH was integrated into family planning, women prime ministers began to break down existing policies to include more specified and targeted provisions. These two methods of prioritization are not incongruous; it seems that only after MCH received an increased amount of funding through its linkage with family planning (which occurred under both women and men prime ministers), could it be prioritized as a separate entity (by women prime ministers).

While the Five Year Plans that were put into place prior to the women prime ministers all addressed health in some way, often MCH and often through population control programmes, it is clear that women were more likely to implement new and distinct policies within the Five Year Plans. This can be observed in their aforementioned focus on nutrition, as well as other programs they started that related to women's empowerment. Bhutto established a new Ministry and the Women's Bank, essentially forming new infrastructure that was specifically geared toward improving women's status. In Bangladesh, the HPSS, HPSP, and HNPSP were all initiated under women prime ministers. India and Bangladesh both saw the installation of a national health policy under women prime ministers, which showed their active methods of nationalizing healthcare.

Table 1: Targeted Programs under Women Prime Ministers

| Bangladesh | India | Pakistan |
|---|---|---|
| HPSP/HPSS (ESP) | Minimum Needs Programme | Ministry of Women's Division |
| HNPSP | Special Nutrition Programme | Social Action Program |
| National Health Policy of Bangladesh (2000) | National Health Policy of India (1983) | Women's Bank |

## Coding Five Year Plans

Coding for prioritization of MCH in Five Year Plans yields interesting results. Through a search for the terms "child", "mother", "matern", and "girl", it became clear that Plans formed in the early years of independence in Pakistan and India had more mentions of the terms than in later years; however, the terms ("child" in particular) were mostly concentrated in the categories of health, social welfare, and education. Moving into subsequent Plans, the categories within which MCH was discussed narrowed slightly. Observations regarding the placement of the coded terms within each Five Year Plan support the descriptive analysis in the above sections. In Tables 2 and 3, the chapters of the Plans that mentioned any of the coded terms are listed in the order of most to least mentions. The chapters are also sorted by color, to make comparable chapters visible and traceable within and throughout both Plans.

Over the course of Indira Gandhi's terms as prime minister, the chapters of national Plans that discuss MCH changed and became more specified, as she narrowed the scope of broader ideas such as health and education to take on an increased focus on gender equality. Table 2 shows how she introduced the category of "food and nutrition" in the Fourth Plan, which had 32 mentions of "child/children", 5 mentions of "mother/s", and 1 mention of "maternal/maternity". In the Sixth Plan, she introduced two new categories that were unique in having mentions of every coded term. "Health, family planning, and nutrition" had 51 mentions of "child/children", 17 mentions of "mother/s", 10 mentions of "maternal/maternity", and 2 mentions of "girl/s" (Table 2). This shows her goal of integrating nutrition into family planning was not only an abstract concept, but also was articulated through the groupings of the Plan. The chapter on "women and development" had 16 mentions of "child/children", 7 mentions of "mother/s", 5 mentions of "maternal/maternity", and 19 mentions of "girl/s" (Table 2).

It is less evident that Bhutto used the Five Year Plans to create new chapters to target and increase mentions of MCH. Before Bhutto took office, the Sixth Plan of Pakistan included a chapter on "women's development and equality of opportunity". This is somewhat surprising given the attitude toward women of General Zia's regime, but it is indicative that as his reign was coming to an end, he faced pressure to reform his views on women from facets of the government that did not approve of his harsh measures. In the Seventh Plan, Bhutto renamed that chapter "women's development, a national imperative", which moved it slightly away from its previous focus on potential mechanisms to allow women equal opportunity, and toward actual improvements and integration of women into the public sphere. Additionally, in the Seventh Plan, Bhutto upgraded the chapter on "health" to include "health and nutrition". This was geared toward MCH, as a major aim of this Plan in terms of health was to combat malnutrition of mothers and children, who represent the most vulnerable portions of the population.

Examining the differences between Table 2 and Table 3 also provides an interesting look at the variation in MCH policies under women prime ministers. There is some evidence to show that Pakistan moved at a slower rate in terms of establishing gender equality in the public sphere. Bhutto's initial Manifesto and her subsequent difficulty in sticking to her promises provided a circumstance where it was clear that a woman prime minister showed intentions of substantive representation, but was held back by the political system.

Table 2: *Mentions of MCH in India's Five Year Plans*

| INDIA: | Child | Mother | Matern* | Girl |
|---|---|---|---|---|
| First Plan (1951-1956) Chair: Jawaharlal Nehru | Social Welfare: 107<br>Health: 41<br>Education: 29<br>Welfare of Backward Classes: 4<br>Displaced persons: 3 | Social welfare: 5<br>Health: 7<br>Education: 1 | Health: 31<br>Social welfare: 3<br>Labour: 3 | Education: 26<br>Social welfare: 5 |
| Second Plan (1956-1961) Chair: | Health: 18<br>Education: 12<br>Social welfare services: 7<br>Approach to Second Plan: 5 | Health: 2<br>Labour policy + programme: 1 | Health: 10<br>Labour policy + programme: 1 | Education: 18<br>Administrative tasks + organization: 1 |

| | | | | |
|---|---|---|---|---|
| Jawaharlal Nehru | Development of economy: 2<br>Place of land reform: 1<br>Community development + national extension: 1<br>Displaced persons: 1<br>Housing: 1<br>Labour policy + programme: 1<br>Welfare of backwards classes: 1 | | | |
| Third Plan (1961-1966)<br>Chair: Jawaharlal Nehru | Education: 36<br>Health + family planning: 29<br>Welfare programmes + social welfare: 26<br>Third Plan outline: 11<br>Long-term economic development: 1<br>Ten years of planning: 2<br>Personnel requirements + training programs: 2<br>Labour policy: 2<br>Public cooperation + participation: 2<br>Scientific + technological research: 2<br>Development of backward classes: 2<br>Animal husbandry, dairying + fisheries: 1<br>Housing + urban + rural planning: 1 | Education: 1<br>Health + family planning: 2 | Health + family planning: 13<br>Ten years of planning: 1<br>Third plan outline: 1<br>Scientific and technological research: 1<br>Development of backward classes: 1<br>Welfare programmes + social welfare: 1 | Education: 58<br>Welfare programs + social welfare: 3<br>Third Plan outline: 1<br>Balanced regional development: 1<br>Technical education: 1 |
| Fourth Plan (1969-1974)<br>**Chair: Indira Gandhi** | Social welfare: 34<br>Food and nutrition: 32<br>Education and manpower: 14<br>Health + family planning: 6<br>Welfare + development of backward classes: 3<br>Approach to policy: 2<br>Preface: 1<br>Long-term perspective: 1<br>Other programmes: 1 [re: census] | Food + nutrition: 5<br>Health + family planning: 2<br>Social welfare: 1 | Food + nutrition: 1<br>Health + family planning: 2 | Education + manpower: 29<br>Social welfare: 4<br>Welfare + development of backward classes: 1 |
| Fifth Plan (1974-1975)<br>**Chair: Indira Gandhi** | Plan outlays to programmes of development: 9<br>The perspective: 1 | Plan outlays to programmes of development: 1 | Plan outlays to programmes of development: 2 | Plan outlays to programmes of development: 4 [re: enrollment] |
| Sixth Plan (1980-1985)<br>**Chair: Indira Gandhi** | Social welfare: 58<br>Health, family planning + nutrition: 51<br>Education: 41<br>Labour + labour welfare: 20<br>Women + development: 16<br>Minimum Needs Programme: 10<br>Development of backward classes: 8<br>Plan implementation, monitoring + evaluation: 3<br>Rural development + cooperation: 3<br>Science + technology: 3<br>Development performance: 2<br>Manpower + employment: 2 | Health, family planning + nutrition: 17<br>Women + development: 7<br>Social welfare: 5<br>Minimum Needs Programme: 2<br>Development performance: 1<br>Labour + labour welfare: 1<br>Science + technology: 1 | Health, family planning + nutrition: 10<br>Women + development: 5<br>Labour + labour welfare: 4<br>Social welfare: 1<br>Development perspective 1979-80 to 1994-5: 1<br>Development of backward classes: 1 | Women + development: 19<br>Education: 13<br>Development of backward classes: 3<br>Social welfare: 3<br>Health, family planning + nutrition: 2<br>Minimum needs programme: 2<br>Science + technology: 2 [re: inclusion in field]<br>Manpower + employment: 1 |

| | | | | |
|---|---|---|---|---|
| | Policy framework: 2<br>Development perspective 1979-80 to 1995-95: 1<br>Communications, information + broadcasting: 1<br>Housing, urban development + water supply: 1 | | | |

Table 3: *Mentions of MCH in Pakistan's Five Year Plans*

| PAKISTAN | Child | Mother | Matern* | Girl |
|---|---|---|---|---|
| First Plan (1955-1960)<br>Chair: Ali Khan | Social welfare: 35<br>Education + training: 23<br>Population + manpower: 10<br>Outline of the Plan: 8<br>Health: 6<br>Labour + employment: 2<br>Special areas + other tribal territories: 2<br>Social + economic objectives: 1<br>Planning the development programme: 1 | Health: 2<br>Social welfare: 1<br>Population + manpower: 1 | Health: 9<br>Outline of the Plan: 4<br>Labour + employment: 4<br>Social welfare: 1 | Education + training: 18<br>Health: 4<br>Outline of the Plan: 2<br>Special areas + other tribal territories: 2 |
| Second Plan (1960-1965)<br>Chair: Ayub Khan | Social services: 29<br>Education + training: 9<br>Manpower + employment: 9<br>Health: 7<br>Population: 5<br>Background, characteristics + size of Plan: 2<br>Development of physical resources: 1 | Health: 2<br>Social services: 1 | Health: 6<br>Background, characteristics + size of Plan: 1<br>Manpower + employment: 1 | Education + training: 10<br>Social services: 1 |
| Third Plan (1965-1970)<br>Chair: Ayub Khan | Social welfare: 31<br>Education + training: 28<br>Health: 19<br>Regional development: 7<br>Long-term perspective: 4<br>Manpower training + labour: 4<br>Family planning: 3<br>Physical planning + housing: 3<br>Objectives, size + structure: 2<br>Review of the plan developed: 1<br>Private investment: 1 | Social welfare: 2<br>Health: 1 | Health: 17<br>Regional development: 2<br>Review of the Plan developed: 1<br>Manpower training + labour: 1<br>Family planning: 1<br>Social welfare: 1 | Education + training: 5<br>Long-term perspective: 2<br>Social welfare: 1 |
| No Plan Period (1971-1976)<br>Chair: Zulfikar Ali Bhutto | Social welfare: 16<br>Education + training: 9<br>Health: 8<br>Social policy: 2<br>Labour policy + services: 2<br>Size, structure + targets: 1<br>Population + family planning: 1<br>Agriculture: 1<br>Physical planning + housing: 1 | Health: 1<br>Social welfare: 1 | Health: 4<br>Social welfare: 1<br>Labour policies + services: 1 | Education + training: 10<br>Social policy: 1<br>Rural development + works programme: 1<br>[re: "girls' school buildings]<br>Development programme for West Pakistan: 1<br>[re: vocational school for girls] |
| Fifth Plan (1978-1983)<br>Chair: Zia-ul-Haq | Social welfare: 31<br>Education + training: 31<br>Health: 14<br>Population planning: 10<br>Rural development: 6 | Social welfare: 5<br>Health: 2<br>Population planning: 2<br>Education + training: 1<br>Rural development: 1 | Health: 4 | Education + training: 50<br>Population planning: 2<br>Azed Kashmir: 1<br>Federally Administrated Tribal Areas (FATAS): |

| | | | | |
|---|---|---|---|---|
| | Azad Kashmir (region): 5<br>Urban development: 3<br>Mass media: 1<br>Physical planning + housing: 1<br>Federally Administrated Tribal Areas (FATAS): 2<br>Northern areas: 1 | Azed Kashmir (region): 1 | | 6<br>Northern areas: 7 |
| Sixth Plan (1983-1988)<br>Chair: Zia-ul-Haq | Social welfare + special education, care for the neglected: 36<br>Health: 35<br>Population welfare, correcting the misdirected investment: 13<br>Education: 13<br>Women's development, equality of opportunity: 10<br>Development strategy of Sixth Plan: 7<br>Social areas, expanding development frontiers: 3<br>Baluchistan, the new agrarian frontier: 3<br>Successes + failures of planned development: 2<br>Rural development: 2<br>Income + employment policy, just reward for work: 1 | Women's development, equality of opportunity: 10<br>Health: 7<br>Population welfare, correcting the misdirected investment: 5<br>Education: 2<br>Social welfare + special education, care for the neglected: 2<br>Development strategy of Sixth Plan: 1<br>Baluchistan, the new agrarian frontier: 1 | Health: 8<br>Population welfare, correcting the misdirected investment: 5<br>Development strategy of Sixth Plan: 1 | Education: 29<br>Special areas, expanding development frontiers: 8<br>Women's development, equality of opportunity: 5<br>Development strategy of Sixth Plan: 2<br>Successes + failures of planned development: 1<br>Rural development: 1<br>Health: 1<br>Population welfare + special education, care for the neglected: 1 |
| Seventh Plan (1988-1993)<br>**Chair: Benazir Bhutto** | Human balance sheet: 33<br>Social welfare: 20<br>Health + nutrition: 19<br>Education + training: 16<br>Population welfare programme: 15<br>Women's development, a national imperative: 9<br>Poverty alleviation strategy: 9<br>Lessons from Sixth Plan: 7<br>Improving distribution of economic benefits: 7<br>Objectives + strategy: 1<br>National consumption plan: 1 | Women's development, a national imperative: 5<br>Human balance sheet: 4<br>Population welfare programme: 4<br>Health + nutrition: 4<br>Social welfare: 3<br>Improving distribution of economic benefits: 1<br>Poverty alleviation strategy: 1 | Health + nutrition: 9<br>Women's development, a national imperative: 3<br>Lessons from Sixth Plan: 2<br>Human balance sheet: 1<br>Population welfare programme: 1 | Education + training: 15<br>Women's development, a national imperative: 15<br>Poverty alleviation strategy: 6<br>Rural transformation: 4<br>Human balance sheet: 2<br>Developing the North-West frontier province: 1<br>Health + nutrition: 1 |
| Eighth Plan (1993-1998)<br>**Chair: Benazir Bhutto** | Health + nutrition: 31<br>Social welfare: 19<br>Education + training: 16<br>Approach to Eighth Plan: 15<br>Enabling environment: 13<br>Balance of growth: 8<br>Performance of Seventh Plan: 5<br>Population welfare: 4<br>Landmarks of Eight Plan: 1 [re: immunization]<br>Perspective Plan (1993-2008): 2<br>Development of social + economic statistics: 1 | Health + nutrition: 6<br>Approach to Eighth Plan: 5<br>Balance of growth: 3<br>Population welfare: 2<br>Social welfare: 2<br>Landmarks of Eighth Plan: 1<br>Perspective Plan (1993-2008): 1<br>Development of social + economic statistics: 1 | Health + nutrition: 5<br>Approach to Eighth Plan: 5<br>Enabling environment: 2<br>Performance of Seventh Plan: 1<br>Population welfare: 1 | Education + training: 27<br>Approach to Eighth Plan: 18<br>Balance of growth: 15<br>Enabling environment: 3<br>Performance of Seventh Plan: 2<br>Health + nutrition: 1<br>Landmarks of Eighth Plan: 1<br>Critical issues: 1<br>Development of social + economic statistics: 1 |

# Chapter 4: Conclusions and Recommendations

## Conclusions

There is sufficient evidence to disprove the claim that women prime ministers are no more likely than men to bring issues of MCH to the forefront of national politics. Thus, there is an indication of substantive representation in the national level of government. Cross-country trends (see Results) strongly suggest that women prime ministers have a tendency to implement new and different policies when they enter office. The manner in which they implemented policies was strategic and aimed toward streamlining MCH improvements while promoting growth in other sectors as well.

The trajectory that was observed when ranking each case study's prioritization of MCH indicated a linear move from low to high levels of prioritization. This was a significant result, because it implies that there may be a natural course that low-income countries take toward prioritizing MCH after gaining independence. However, the fact that the jump from level 2 of MCH prioritization to level 3 of MCH prioritization only occurred when women were in office raises the idea that women are catalysts for change.

These conclusions are important, especially in the context of a global trend in women's increased participation in politics. Previous research has tended to focus on the effectiveness of each woman's policies, rather than the scope of the policies. In other words, because MCH indicators did not necessarily show improvements under a woman prime minister's regime, there may be an assumption that substantive representation does not exist on the national level. From the perspective of the present study, it is still an important and accurate measure of priorities to examine the policies that were put into place. Whether or not a policy was "effective" in meeting

its goal must take into account a substantial number of outside influences, which could confound the results.

Finally, consistencies that were observed in the political climate and circumstances directly preceding a woman minister raise the following question: can a country ever be considered "ripe" for a women leader? That is to say, a ruling government that is experiencing some shift, be it economic, social, religious, or ideological, may open the playing field to a gender change in leadership. From data shown in the present study, it seems that a unique set of circumstances predate the first term that a woman is prime minister; codified gender inequities, social unrest, regime changes and overall political turmoil were all factors leading up to a women's term in office. If these trends were established worldwide, it might also explain why women as national leaders have not been analyzed more often—entering office during periods of political unrest further complicates the task of evaluating a leader.

## Limitations of Study

The greatest challenge presented in this research was the lack of consistent data. "Expenditure in the health sector in general and in MCH in particular is not well documented" (Siddiqi et al. 2004, p. 124). Thorough research into the allocations of national gross domestic product (GDP) of each case study was conducted, but yielded no consistent results; countries do not track their expenditure on health in comparable ways. Considering the importance of funding as one measure of political priorities, data on GDP allocations should be better available for policy research. Increased transparency of data would allow for more thorough examinations of national health policies, which in turn could improve future planning and encourage political leaders to learn from mistakes. The World Bank contains many economic, health, and gender-related indicators, such as health expenditure per capita, total public health expenditure, pregnant

women receiving prenatal care, and births attended by skilled health staff; however, the data are not provided for years prior to 2000. Peabody et al. (1999) noted that "since 1960, there has been a four-fold increase in the amount of money that developing governments in Asia have spent on improving their people's health". However, the authors did not delve into the specific funding and mechanisms used to improve health, and it is unclear whether or not they accounted for inflation. It would benefit future research on health policies to be able to track various governments' budget allocations toward health throughout the twentieth century, especially since countries are moving from low- to middle-income economies.

Although all of the countries that were chosen for case studies create policies via Five Year Plans, not all of the Plans were available to research in the same manner. The governments of India and Pakistan post many publications dating as far back as independence. Bangladesh, on the other hand, has not turned their publications into electronic sources. These documents only exist in print in very few libraries abroad. India, as the largest country in South Asia and second most populous in the world, has much more written about it in global health and social science literature. Given that India is also the world's largest democracy, and is considered by many the new economic "powerhouse" of South Asia, it makes sense that scholars and policymakers give India increased attention in comparison with Pakistan and Bangladesh.

There were a few inherent limitations that were predicted from the onset of this study. When attempting to sort through and understand the motives of any politician, it is crucial to remember that they are at the mercy of their electorates, and if they are seeking reelection, they must respond to the expectations of the people. Political analysts therefore can never be certain as to which issues politicians truly care about versus what they consider a strategic move. Therefore, the type of information as well as accessibility proved to be barriers for this study.

Finally, an inherent limitation in most analytic research is the personal bias that the researcher brings into the study. Saldana (2009) notes how one's "level of personal involvement as a participant observer… filters how you perceive, document, and thus code your data" (p. 7). This study was obviously shaped by my position in society as a middle-class, college-educated woman with a background in gender issues. I also hold no personal ties to the countries in this study, which may have helped with objectivity but not necessarily with painting a picture of the political, social, or cultural contexts. Thus, the methodologies of the study were ultimately geared toward overarching gender and policy findings, possibly at the risk of overlooking important country-specific variables. Essentially, the same factors that sparked the initial interest will be reflected in the interpretation and analysis of the findings (Saldana 2009).

Overall, it is clear that analyzing global health from a historical and political perspective poses many difficulties. There is a limited amount of data at the national level regarding health policies, and there is no set standard for tracking such data before the turn of the century. There are inherent shortcomings in including the necessary data for this study due to the dearth of country level transparency and cohesion. In sum, this is still a developing field that should seek to become more comprehensive and consistent.

## Recommendations

### Recommendations for Future Analysis

It is interesting and somewhat surprising that the policies of women as national leaders have not been analyzed and tested for substantive representation. In that vein, the most important realization that emerged from this study was the fact that scholars and policymakers alike do not really know how to analyze or make sense of a woman as a major political leader. This is evident from the pervasiveness of the "double bind" that women are held to in many walks of life.

Jamieson (1995) uses Hilary Clinton as an example of a "surrogate on whom we projected out attitudes about attributions once thought incompatible, that women either exercised their minds or had children but not both, that women who were smart were unwomanly and sexually unfulfilled, that articulate women were dangerous" (p. 23). Hilary Clinton has been overanalyzed by political pundits, criticized by the media for being too "hard", "tough", "aggressive", and "feminist" (p. 38). When she tried to "soften" herself—politicians must, after all, appeal to their constituents—she was characterized again on the basis of pandering to her own gender.

It is clear that society holds women to a double standard, which those standards, given that it is impossible to be at both ends of the gendered characterization of politicians, there are more questions regarding the relationship between gender and politics than there are answers. The fact that all women leaders cannot be classified in the same manner may prove problematic for analysts, but it is not necessarily bad for equality; it shows how varied their styles of leadership can be, and disproves claims that attempt to essentialize or oversimplify the nature of women in politics. In a way, this failure on the part of analysts undermines the idea that women must assimilate to politics. Another important thing that I gleaned from the research on these topics is the difference in titling women in high elected positions versus men. Men were consistently introduced by their full name first, and then subsequently referred to by last name only. Women on the other hand, were introduced by their full name and then by their association to their well-known husbands or fathers. Subsequent mentions often included the title of "Mrs." or "Ms." before their last names, giving the impression that it was always necessary to define these leaders by their gender or family status. This demonstrates how women as leaders are not only gendered by the issues that they represent and their leadership styles, but also by their very identification.

While the present analysis did not take into account policymaking in international relations, it must be mentioned that each woman examined in this paper has a reputation for taking a strong stance on state and security issues. Their tenures as prime ministers were, and continue to be highly controversial in that regard; these women were not known to shy away from difficult decisions that they knew might lose them votes, or take a backseat to serious problems of their countries. While the policies that they enacted may not be considered successes today, these women were hands-on leaders and solid diplomats. In fact, some have said that they displayed tough, "masculine" qualities in their leadership styles. This fact further complicates the gender discourse in politics, as it calls into question many of the assumptions that hinder women from taking on leadership roles in the first place. The historic and pervasive belief that women are not suited for political leadership carries on today in society's need to assign a gender description to the actions and policies of women when they are in office. When women hold a high-ranking position (in government, business, etc.) and make difficult decisions, they are perceived as not acting in a "feminine" manner, and because of the gender binary in society, they therefore must be acting in a "masculine" manner (Jamieson 1995). Assumptions or predictions about the impact of a woman's gender, or "femininity", on her *ability* to govern are unproductive. Much more research into the political behavior (i.e. substantive representation) of women in high elected positions is necessary to better understand the factors that do contribute to policymaking.

Throughout the research, it became clear that scholarship has not attempted to link the gender of national leadership with the types of policies put into place. It seems that the concept of substantive representation exists only in specific gender studies journals, rather than in the greater discourse on national policy and global health. From the research conducted in this study,

it seems that the underlying question that should be addressed more explicitly by scholars is whether women's empowerment leads to developments, or whether development leads to women's empowerment. Both of these possibilities have been represented within different contexts throughout the paper; many Plans include sections called "women and development", which provide an example of how women would benefit from development strategies, while at the same time, other research shows how women have the potential to improve development indicators such as MCH, sanitation and education. This disparity leads to the conclusion that a country's stage of development has a complicated impact on opinions about gender and politics that has not been sufficiently examined.

Lena Wangnerud (2006) describes the "trade-off" between contextualizing countries on an individual basis versus a cross-comparison that yields trends in results. Her recommendation is for "the development of a set of standard definitions and indicators that enable good cross-country comparative research" (p. 64). The conclusions provided here fall in line with both her concern and her recommendation; delving into each case study showed the dozens of dependent variables that exist within each country's system, however the cross-country comparison still yielded trends that disproved the null hypothesis.

### Recommendations for Future Policies

Jahan (1987) makes an interesting point about South Asian women leaders—namely, Indira Gandhi, Sirimavo Bandaranaikre, Benazir Bhutto, Sheikh Hasina, and Khaleda Zia—and their rise to power; "they all fall into the category of leaders whose assumption of power was 'mediated' by a male relative, as opposed to those whose careers were shaped from the beginning by their own choices, attributes and efforts, grounded in a strong sense of their own political efficacy" (p. 850). This raises some critical questions: primarily, would the results of

substantive representation be different if this had not been the case? It is possible that their relatives, often men who established notoriety as party founders, presidents, or prime ministers themselves, shaped each woman's public opinion or reputation within parliament. There is undeniably a higher status that goes along with having a famous family name, and it is clear that these women were granted a certain amount of privilege throughout their lives. From the data analyzed above, it appears that there is a certain degree of diminishing returns on the effects of substantive representation. I hypothesize that a woman prime minister who comes from a privileged background but lives in a low-income country can never truly represent the "average" woman, on the grounds that she would never have experienced the daily life of the vast majority of her electorate.

True representation would necessitate a drastic shift to "even the playing field" in terms of available opportunities for women worldwide. Aside from ensuring better health outcomes, ending the vicious cycle of poverty and promoting education are important factors in giving women who start life in a lower class of society the potential to move up the ladder of success and partake in government. "The absence of poor women's voices in policy making strips development strategies of critical information for improving the health of the poor and promoted a disconnect between policy dialogue and health objectives" (Sen et al. 2002). Using substantive representation to test for other aspects of a person's identity and background could potentially have implications that are just as powerful as those that relate to gender.

## Closing the Gender Gap

This study supports the opinion that many different voices should be represented in formal politics, especially at the national level. Someone's political "voice" comes from his or her experiences and beliefs, which are formed and reformed through the process of socialization.

Gender, race, class, religion, and other intersecting sociodemographic variables contribute to how people interact with the world, and the expectations that society sets for them not only as individuals but also as members of a group. However, it is evident that the large majority of voices that are represented in formal politics are not varied in a way that reflects the multitude and multiplicity of the human experience. In order for policies to truly reflect the needs of the populace, it would make sense that the leadership more accurately demonstrates those variations.

At the onset of this research, it was predicted that large, sweeping changes toward MCH issues would be observed under the leadership of women, but this was found to be only somewhat true. Women for the most part created special programs that increased national attention toward MCH issues within the preexisting system of policymaking. They also can be viewed as the catalysts for change, as each woman significantly increased her country's national prioritization of MCH. The benefits of bringing women into politics and policymaking are clear. Gender quotas have empowered women in many parts of the world, and when women achieve political power in the U.S. and Europe, adolescent girls are more likely to show an affinity for current events and a desire to one day enter the political sphere. If assigning certain political issues a gender is the current way for women to achieve success in politics, then it should not be viewed as a negative thing. Women are still working to make visible the everyday problems that have been historically coopted by men for their own pursuits. In the coming years, however, we should look past the goal of increasing women's numeric representation in politics. A cultural shift from a world that continues to view women outside the normative structure of politics to a world that sees "women's issues" as another element of "human issues" is one where the gender gap can finally be closed.

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# Appendix

## I. Diagram on Vicious Cycle of Malnutrition

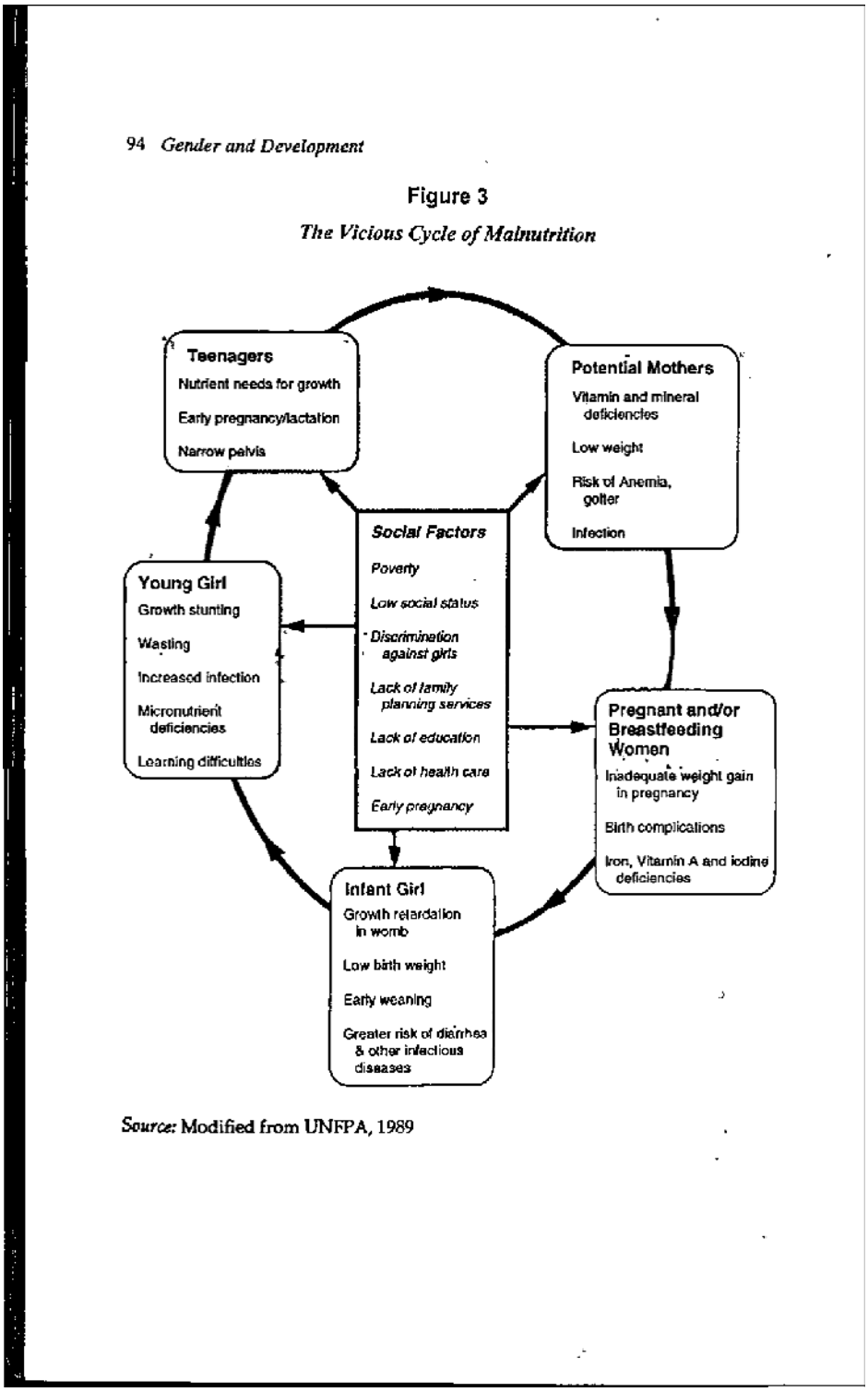

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Figure 3

*The Vicious Cycle of Malnutrition*



*Source:* Modified from UNFPA, 1989

(Haider 1995, p. 94)

## II. Coding India's Five Year Plans

| INDIA: | Child | Mother | Matern* | Girl |
|---|---|---|---|---|
| First (1950-1955) | Health: 41<br>Education: 29<br>Social Welfare: 107<br>Welfare of Backward Classes: 4<br>Displaced persons: 3 | Health: 7<br>Education: 1<br>Social welfare: 5 | Health: 31<br>Labour: 3<br>Social welfare: 3 | Education: 26<br>Social welfare: 5 |
| Second Plan (1955-1960) | Development of economy: 2<br>Social welfare services: 7<br>Approach to second 5 year plan: 5<br>Place of land reform: 1<br>Community development + national extension: 1<br>Displaced persons: 1<br>Education: 12<br>Health: 18<br>Housing: 1<br>Labour policy + programme: 1<br>Welfare of backwards classes: 1 | Health: 2<br>Labour policy + programme: 1 | Health: 10<br>Labour policy + programme: 1 | Administrative tasks + organization: 1<br>Education: 18 |
| Third Plan (1960-1965) | Long-term economic development: 1<br>Ten years of planning: 2<br>Third Plan outline: 11<br>Personnel requirements + training programs: 2<br>Labour policy: 2<br>Public cooperation + participation: 2<br>Animal husbandry, dairying + fisheries: 1<br>Education: 36<br>Scientific + technological research: 2<br>Health + family planning: 29<br>Development of backward classes: 2<br>Housing + urban + rural planning: 1<br>Welfare programmes + social welfare: 26 | Education: 1<br>Health + family planning: 2 | Ten years of planning: 1<br>Third plan outline: 1<br>Scientific and technological research: 1<br>Health + family planning: 13<br>Development of backward classes: 1<br>Welfare programmes + social welfare: 1 | Third Plan outline: 1<br>Balanced regional development: 1<br>Education: 58<br>Technical education: 1<br>Welfare programs + social welfare: 3 |
| Fourth Plan (1965-1970) | Preface: 1<br>Approach to policy: 2<br>Long-term perspective: 1<br>Food and nutrition: 32<br>Education and manpower: 14<br>Health + family planning: 6<br>Social welfare: 34<br>Welfare + development of backward classes: 3<br>Other programmes: 1 [re: census] | Food + nutrition: 5<br>Health + family planning: 2<br>Social welfare: 1 | Food + nutrition: 1<br>Health + family planning: 2 | Education + manpower: 29<br>Social welfare: 4<br>Welfare + development of backward classes: 1 |
| Fifth Plan (1970-1975) | The perspective: 1<br>Plan outlays to programmes of development: 9 | Plan outlays to programmes of development: 1 | Plan outlays to programmes of development: 2 | Plan outlays to programmes of development: 4 [re: enrollment] |
| Sixth Plan (1975-1980) | Development performance: 2<br>Development perspective 1979-80 to 1995-95: 1<br>Policy framework: 2 | Development performance: 1<br>Minimum Needs Programme: 2 | Development perspective 1979-80 to 1994-5: 1<br>Health, family planning + nutrition: 10 | Manpower + employment: 1<br>Minimum needs programme: 2 |

| | | | | |
|---|---|---|---|---|
| | Plan implementation, monitoring + evaluation: 3<br>Rural development + cooperation: 3<br>Manpower + employment: 2<br>Minimum Needs Programme: 10<br>Communications, information + broadcasting: 1<br>Science + technology: 3<br>Education: 41<br>Health, family planning + nutrition: 51<br>Housing, urban development + water supply: 1<br>Labour + labour welfare: 20<br>Development of backward classes: 8<br>Women + development: 16<br>Social welfare: 58 | Science + technology: 1<br>Health, family planning + nutrition: 17<br>Labour + labour welfare: 1<br>Women + development: 7<br>Social welfare: 5 | Labour + labour welfare: 4<br>Development of backward classes: 1<br>Women + development: 5<br>Social welfare: 1 | Science + technology: 2 [re: inclusion in field]<br>Education: 13<br>Health, family planning + nutrition: 2<br>Development of backward classes: 3<br>Women + development: 19<br>Social welfare: 3 |

(Planning Commission of India)

## III. Coding Pakistan's Five Year Plans

| PAKISTAN | Child | Mother | Matern* | Girl |
|---|---|---|---|---|
| First Plan (1955-1960) | Social + economic objectives: 1<br>Outline of the Plan: 8<br>Planning the development programme: 1<br>Population + manpower: 10<br>Labour + employment: 2<br>Education + training: 23<br>Health: 6<br>Social welfare: 35<br>Special areas + other tribal territories: 2 | Population + manpower: 1<br>Health: 2<br>Social welfare: 1 | Outline of the Plan: 4<br>Labour + employment: 4<br>Health: 9<br>Social welfare: 1 | Outline of the Plan: 2<br>Education + training: 18<br>Health: 4<br>Special areas + other tribal territories: 2 |
| Second Plan (1960-1965) | Background, characteristics + size of Plan: 2<br>Development of physical resources: 1<br>Population: 5<br>Health: 7<br>Education + training: 9<br>Social services: 29<br>Manpower + employment: 9 | Health: 2<br>Social services: 1 | Background, characteristics + size of Plan: 1<br>Health: 6<br>Manpower + employment: 1 | Education + training: 10<br>Social services: 1 |
| Third Plan (1965-1970) | Review of the plan developed: 1<br>Long-term perspective: 4 | Health: 1<br>Social welfare: 2 | Review of the Plan developed: 1<br>Regional development: 2 | Long-term perspective: 2<br>Education + training: 5<br>Social welfare: 1 |

| | | | | |
|---|---|---|---|---|
| | Objectives, size + structure: 2<br>Private investment: 1<br>Regional development: 7<br>Education + training: 28<br>Manpower training + labour: 4<br>Health: 19<br>Family planning: 3<br>Social welfare: 31<br>Physical planning + housing: 3 | | Manpower training + labour: 1<br>Health: 17<br>Family planning: 1<br>Social welfare: 1 | |
| No Plan Period (1971-1976) | Size, structure + targets: 1<br>Social policy: 2<br>Education + training: 9<br>Labour policy + services: 2<br>Health: 8<br>Population + family planning: 1<br>Social welfare: 16<br>Agriculture: 1<br>Physical planning + housing: 1 | Health: 1<br>Social welfare: 1 | Labour policies + services: 1<br>Health: 4<br>Social welfare: 1 | Social policy: 1<br>Education + training: 10<br>Rural development + works programme: 1<br>[re: "girls' school buildings]<br>Development programme for West Pakistan: 1<br>[re: vocational school for girls] |
| Fifth Plan (1978-1983) | Mass media: 1<br>Physical planning + housing: 1<br>Education + training: 31<br>Health: 14<br>Population planning: 10<br>Social welfare: 31<br>Rural development: 6<br>Urban development: 3<br>Azad Kashmir (region): 5<br>Federally Administrated Tribal Areas (FATAS): 2<br>Northern areas: 1 | Education + training: 1<br>Health: 2<br>Population planning: 2<br>Social welfare: 5<br>Rural development: 1<br>Azed Kashmir (region): 1 | Health: 4 | Education + training: 50<br>Population planning: 2<br>Azed Kashmir: 1<br>Federally Administrated Tribal Areas (FATAS): 6<br>Northern areas: 7 |
| Sixth Plan (1983-1988) | Successes + failures of planned development: 2<br>Development strategy of Sixth Plan: 7<br>Rural development: 2<br>Baluchistan, the new agrarian frontier: 3<br>Social areas, expanding development frontiers: 3<br>Education: 13<br>Health: 35<br>Women's development, equality of opportunity: 10<br>Population welfare, correcting the | Development strategy of Sixth Plan: 1<br>Baluchistan, the new agrarian frontier: 1<br>Education: 2<br>Health: 7<br>Women's development, equality of opportunity: 10<br>Population welfare, correcting the misdirected investment: 5<br>Social welfare + special education, care for the neglected: 2 | Development strategy of Sixth Plan: 1<br>Health: 8<br>Population welfare, correcting the misdirected investment: 5 | Successes + failures of planned development: 1<br>Development strategy of Sixth Plan: 2<br>Rural development: 1<br>Special areas, expanding development frontiers: 8<br>Education: 29<br>Health: 1<br>Women's development, equality of opportunity: 5<br>Population welfare + special education, care for the neglected: 1 |

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| | misdirected investment: 13<br>Social welfare + special education, care for the neglected: 36<br>Income + employment policy, just reward for work: 1 | | | |
| Seventh Plan (1988-1993) | Lessons from Sixth Plan: 7<br>Improving distribution of economic benefits: 7<br>Objectives + strategy: 1<br>Human balance sheet: 33<br>Poverty alleviation strategy: 9<br>National consumption plan: 1<br>Education + training: 16<br>Health + nutrition: 19<br>Population welfare programme: 15<br>Women's development, a national imperative: 9<br>Social welfare: 20 | Improving distribution of economic benefits: 1<br>Human balance sheet: 4<br>Poverty alleviation strategy: 1<br>Health + nutrition: 4<br>Population welfare programme: 4<br>Women's development, a national imperative: 5<br>Social welfare: 3 | Lessons from Sixth Plan: 2<br>Human balance sheet: 1<br>Health + nutrition: 9<br>Population welfare programme: 1<br>Women's development, a national imperative: 3 | Human balance sheet: 2<br>Poverty alleviation strategy: 6<br>Rural transformation: 4<br>Developing the North-West frontier province: 1<br>Education + training: 15<br>Health + nutrition: 1<br>Women's development, a national imperative: 15 |
| Eighth Plan (1993-1998) | Landmarks of Eight Plan: 1<br>[re: immunization]<br>Performance of Seventh Plan: 5<br>Perspective Plan (1993-2008): 2<br>Approach to Eighth Plan: 15<br>Enabling environment: 13<br>Balance of growth: 8<br>Education + training: 16<br>Health + immunization: 31<br>Population welfare: 4<br>Social welfare: 19<br>Development of social + economic statistics: 1 | Landmarks of Eighth Plan: 1<br>Perspective Plan (1993-2008): 1<br>Approach to Eighth Plan: 5<br>Balance of growth: 3<br>Health + nutrition: 6<br>Population welfare: 2<br>Social welfare: 2<br>Development of social + economic statistics: 1 | Performance of Seventh Plan: 1<br>Approach to Eighth Plan: 5<br>Enabling environment: 2<br>Health + nutrition: 5<br>Population welfare: 1 | Landmarks of Eighth Plan: 1<br>Performance of Seventh Plan: 2<br>Approach to Eighth Plan: 18<br>Enabling environment: 3<br>Critical issues: 1<br>Balance of growth: 15<br>Education + training: 27<br>Health + nutrition: 1<br>Development of social + economic statistics: 1 |

(Planning Commission of Pakistan)