PULSE
UPDATING YOU ON HEALTH DEVELOPMENTS

2. THE EFFECTS OF POVERTY, CASTE AND ETHNICITY ON ACCESS TO HEALTH SERVICES

POVERTY, CASTE AND ETHNICITY BASED BARRIERS

Narratives from poor Other Backward Class (OBC), poor hill Brahmin and Chhetri, Madhesi Dalit, Muslim, and Janajati (ethnic group) study participants revealed generic poverty related, and specific caste, ethnic and religious barriers to accessing health care. Poverty is a key determinant of access to services that is compounded by caste and ethnicity-related barriers.

Participants in the Access to Health Services Study (Thomas et al. 2012) regularly labelled themselves both by ethnic, religious or caste group and by economic or educational status (for example: "I am a poor Dalit") and never solely by one factor.

"I don't have money. My husband works in a brick factory in a neighbouring village, and he can't save any money from there. If some health problem occurs we have to borrow money to buy medicine… We are also a Muslim family. Women are kept hiding from others, inside veils. The health centre is very far so pregnant women can't walk that far, and the transport costs are too high."

Female, Rautahat

Queuing for an eye examination, Bhutaha General Hospital, Saptari

THE ACCESS TO HEALTH SERVICES STUDY

A study was carried out in 2012 to understand the socio-cultural, economic and institutional barriers that poor and excluded people face accessing health services in Nepal. It used the rapid participatory ethnographic evaluation and research (rapid PEER) method, which is designed to explore sensitive issues with non- and low literate marginalised populations. Rapid PEER interviews happen in the third person to avoid response biases and are carried out by 'ordinary' members of target groups to elicit frank responses. The study examined experiences of accessing essential health care services at sub-health posts, health posts and outreach clinics.

Six social groups were studied: Chepangs, Muslims, Madhesi Dalits, Other Backward Classes (OBCs or other Madhesi castes), hill Dalits, and poor hill Chhetris and Brahmins, thus covering caste, ethnic, and religious differences. Each group was studied in two districts giving 12 sub-studies with 374 interviews in all.

Eight briefing notes have been produced to disseminate the findings. Note 1 gives the background and methodology while notes 2, 3 and 4 present the findings on the effects on accessing health care of poverty, caste and ethnicity (2); gender (3) and geography (4). Note 5 presents the findings on access to family planning, note 6 on access to safe abortions, note 7 on access to maternal health services and note 8 on access to child immunisation services. The study report (Thomas et al. 2012) is available at http://www.nhssp.org.np/gesi/Nepal%20PEER%20Revised%20Report.pdf

POVERTY DETERMINES WHO RECEIVES HEALTH CARE AND WHEN

The study found that the ability to afford transport, medicines and associated costs, such as paying for tests, is a major barrier to accessing health services in Nepal. Lack of cash or the inability to raise sufficient amounts are compounded by uncertainties about the availability and quality of accessible health services. Families, and especially decision makers, will often decide that the value added from the money spent on health care is not sufficient or cost effective. This is also often a result of the low priority given by poor families to such health care. Even ill women themselves can reinforce the justification that expenses are not required due to their socialisation that they need to save money and be stoic.

Since almost all poor women economically depend on their husbands, their ability to access cash to pay for services is very low. Many families reported not availing of the government's transport incentive to give birth in a health facility, as they could not access the additional amount to pay for the return journey, and thus opted for home-based childbirth.

SOCIAL BELIEFS AND TRADITIONAL DISCRIMINATORY PRACTICES

Social beliefs affecting essential health care services and gender-based discriminatory practices impact the access of all social groups to health services. The mobility constraints of women, especially from Tarai-based caste groups like Other Backward Classes (OBCs), and gendered norms of behaviour (again stricter for OBC women who have to follow exacting notions of female seclusion) impact access to health services. The attitudes of spouses and families prevent OBC women from accessing health services and receiving proper medical care. OBC women have to struggle first at home, second in society and thirdly in facilities to assert their entitlement to health services (Acharya 2010).

SPIRITUAL BELIEFS LEAD TO NON-USE OF MODERN HEALTH SERVICES

Spiritual beliefs interact with poverty and distance from services to reinforce the likelihood of traditional practices being selected over modern health services by poor people. This was reported especially in Chepang communities.

> "In Robang, a daughter of two years had diarrhoea at night. They thought she got caught by a ghost so they took her to the witchdoctor. He attempted the whole night with *tantra mantra* [sacred words], but in vain."
>
> Male, Dhading

A traditional healer from Nepal's hills ready to drive out evil spirits.

Many Chepangs use traditional healers (jhakris) because:

- they believe that illness is caused by angry ancestral gods;
- they lack information and awareness of modern medicine and local health services;
- they fear the unknown procedures and side-effects of modern medicine;
- they lack access to local health facilities; and
- they are poor.

Many Chepangs are moving from traditional to Christian beliefs, and traditional healers are being replaced by a belief in prayers to cure ill health.

> "For minor headache, shivering, fever etc. they go to church and pray together to overcome Satan's illness"
>
> Male, Dhading

Study participants reported that traditional and faith-based healing practices are used because:

- traditional healers provide herbs to prevent and promote pregnancy;
- traditional birthing practices are preferred;
- of the fear of side-effects from modern contraception and immunisation;
- secrecy can be maintained for abortions at an affordable price, providing there are no complications;
- of the belief that traditional healers will cure illnesses; and
- payment in-kind is accepted by traditional healers (e.g. food and alcohol).

CASTE BASED DISCRIMINATION OFTEN LEADS TO SELF-EXCLUSION AMONG DALITS

Madhesi and hill Dalits (the untouchables of the traditional Hindu caste system) are examples of population groups for whom health care is frequently desired but unavailable (or poorly provided) owing to caste-based exclusion. The study found discrimination experienced by Dalits from both health service providers and other community members. Caste-based discrimination by service providers was experienced in three ways:

- *Lack of access to care:* Treatment and medicine that was believed to be available at health facilities was said to have not been received, and outreach services were also reported to be withheld from Dalit patients, such as home visits by female community health volunteers (FCHVs). Such visits were said to be provided to other caste groups.
- *Delayed access to care:* Dalits from hill and Tarai areas reported that they have to wait longer than others at facilities, are often the last to be treated, and, as a result, often have to return home without being treated.
- *Poor quality care:* Reluctance by service providers to have physical contact with Madhesi Dalits results in a lack of physical examinations, discourteous and limited verbal communication and the withholding of non-essential treatment such as deworming.

"One female community health volunteer tells Dalits that she does not like to go to their houses even when they call her."

Female, Doti

"Health workers treat non-Dalit women well and do their check-ups immediately. But they don't treat Dalits and uneducated women well, they don't check us well. No touching us."

Female, Saptari

"Some higher caste people discourage Dalits from getting health care services"

Female, Saptari

"Even if we pay, high caste people don't allow us to use their cart to take a pregnant woman to hospital when she is in labour. Two years ago the wife of a local man was in labour and he wanted to take his wife to the health facilities, but the high caste people did not let him rent their bullock cart."

Male, Saptari

Madhesi Dalits also face discriminatory practices from other community members. This is experienced:

- from more advantaged castes discouraging Dalits from accessing routine services (which further compounds the pressure on women from husbands and parents-in-law not to access care); and
- from more advantaged castes failing to assist Dalits during emergencies, thus exacerbating existing challenges of distance from services, terrain, and lack of transport.

The impact of externally-imposed social exclusion, together with deeply ingrained cultural and social marginalisation results in the self-exclusion of Dalits from available services, owing to their lack of belief that they will receive quality services or due to them wanting to avoid discrimination. Self-exclusion tends to be fluid, however, and is influenced by age and gender, with examples given in the study of older people sending younger men, women, and children to health services, or husbands sending women to see whether health worker practices have changed.

RELIGIOUS BELIEFS RESULT IN NON-ACCEPTANCE (OR COVERT UPTAKE) BY MUSLIMS

Muslim women's access to health services was found to be determined by:

- religious non-acceptance of particular services such as safe abortion and family planning;
- religious codes of practice such as purdah (a state of social isolation); and
- social norms that dictate codes of behaviour such as ensuring that they are not being perceived by others within and outside the family of transgressing religious codes of practice.

The practice of purdah particularly limits communication between married women and men other than husbands, and places strict controls over women's mobility and their use of social and public spaces outside the home. Anxiety about women having to reveal parts of their bodies to male doctors leads to shyness amongst women and self-exclusion from health services. The same concerns also lead to men forbidding women from accessing services.

"There is social stigma. Because of religion, women are not allowed to use contraceptives. They also fear that other villagers will know if they used them. Religion and customs don't allow us to use contraceptives."

Male, Banke

Muslim and other women wait in line at a health facility

Other reasons for self-exclusion were given as the fear of disobeying religious beliefs, the associated strong feelings of shame amongst women and their husbands, and fear of being gossiped about by other local women.

> "Muslims do not take pregnant women to the sub-health post or health post. The religious leaders prohibit that. Even the man feels ashamed as she reveals her body."
>
> Female, Banke

> "In the birthing centre of the health post, male staff also come in. Women feel very embarrassed by this, because they will be without burka."
>
> Male, Banke

ISSUES TO CONSIDER

1. How to encourage policy makers and health practitioners to pay more attention to the ways that poverty, caste, ethnicity, and religion impact access to health services? It is important to recognise that barriers associated with being poor and excluded (and female) occur across all social identities, and a simple association by caste, ethnic or religious identity is inadequate for health service planning and delivery.

2. Can discriminatory behaviour by health service providers be reduced through appropriate training, supervision and management?

3. Can more health workers and FCHVs be recruited from excluded communities?

4. Can outreach services be better targetted to poor and excluded communities that depend on traditional healing or are inhibited from accessing health care services by religious norms?

5. Can information, education and communication materials be developed to help overcome the socio-cultural barriers of specific social groups and their practices, beliefs and languages?

6. How can the health sector work with other government and civil society organisations to support social change and the communication efforts required at family, community, and society levels to address socio-cultural barriers? This could include working with local religious leaders.

7. How to increase awareness of household-level decision makers and other family members on health entitlements and the benefits of accessing health services?

8. Can systems and procedures be established that enable the government to support non-governmental partners to work at the local level to create more demand for health services?

9. How to develop interventions that foster spousal support and strengthen community outreach services to enable men and women to access health services that are contrary to cultural or religious norms?

10. How to strengthen emergency health funds so they provide more cash support for the poor to access health services?

11. What aspects of existing financial subsidy programmes and referral systems need revising to better enable target groups to avail of health services?

12. How to ensure that efforts to access facilities by the poor and socially excluded are successful in terms of facilities being open and visits resulting in the receipt of sensitive, quality care, as far as possible by same-sex providers?

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