NHSSP

PULSE

UPDATING YOU ON HEALTH DEVELOPMENTS

3. THE EFFECTS OF GENDER ON ACCESS TO HEALTH SERVICES

GENDER BASED BARRIERS

The Access to Health Services Study (Thomas et al. 2012), found that the pathway to accessing care is punctuated by barriers in the home, in communities, in reaching health facilities, and in the delivery of the services. For each of these locations and factors, gender-based barriers exist that women reported as deterring them from accessing services for themselves and their children (see Figure 1 overleaf). Those described by study participants as most important are marked with an asterisk.

Only 65% of currently married women participate in decisions about their own health care

MoHP et al. 2012

IN THE HOME

Amongst both hill and Tarai study participants, decision making about health care was said to be almost always gender-based. Women usually have to seek permission from their husbands or parents-in-law to access health services for themselves and their children.

This dependence on husbands and husbands' parents, who almost always control family assets and cash, leads to delays in women accessing services while permission is sought and negotiated. The influence of parents-in-law increases in the common situation where husbands work away from home.

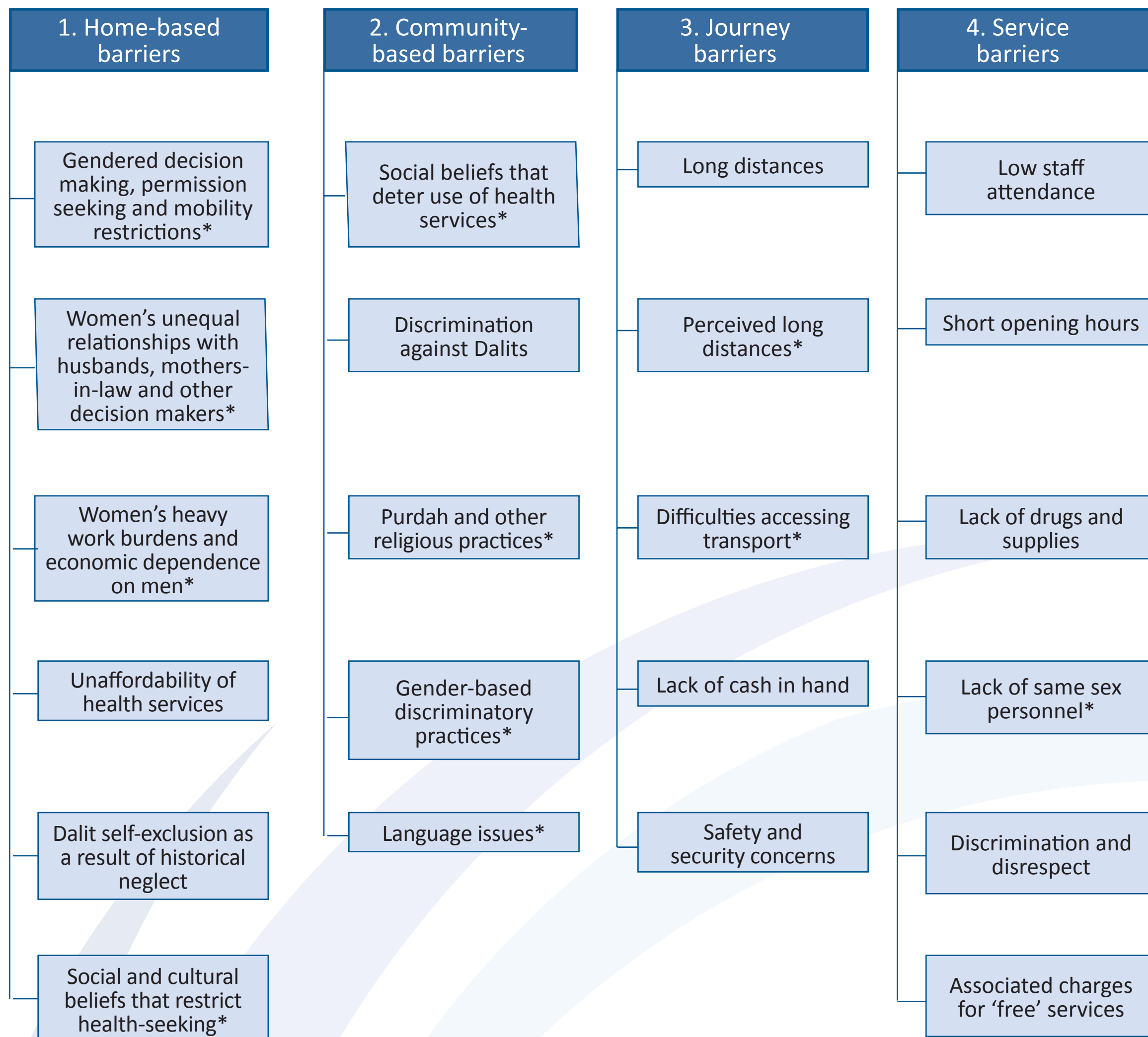
THE ACCESS TO HEALTH SERVICES STUDY

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

Figure 1: Gender based barriers along the pathway to accessing health care



** Denotes the most important perceived barriers to accessing health services*

Women's failure to conform to these and other established gendered norms frequently results in punishment, including gender-based violence. This particularly applies to Madhesi communities where gender norms are more strictly adhered to.

Intra-household social relationships and gender-based practices were said to be established, expected, accepted from one generation to the next, and slow to change. The social and cultural beliefs related to reproductive and maternal health, and perceptions of the value of health care among family members, especially by mothers-in-law, further act as a barrier to accessing health services.

It was widely reported that older women view pregnancy as a 'natural' process of 'normal' women and regard formal maternal health services that were not available to them as unnecessary. They tend to view the use of these services as reducing stoicism, resilience, and physical strength. Hence women seeking such services can be denigrated as weak and attention-seeking, further inhibiting the seeking of such support by pregnant women.

In all the study areas, married women are expected to undertake domestic duties and contribute to household livelihoods. In the hills, lack of time and opportunities to access services are more pronounced as women's work burdens are generally heavier and more strenuous than in the Tarai. Seasonal obligations, such as planting, weeding and harvesting crops and observing festivals, further limit women's opportunities for absences from home. The general view was that women who go absent without permission to attend a health facility face a substantial risk of being punished by family members for not fulfilling their duties.

"If a woman doesn't seek permission then she can be beaten or scolded. If she goes to the health facility without the permission of her husband, he can physically assault her when she returns home. If she goes for health services without permission from her in-laws or husband, a women may be physically assaulted or they will scold her..."

Male, Saptari

Responses from participants showed how women's domestic duties in the hills and Tarai are gender and age-sensitive, which means that others in the family are unlikely to absorb the workloads of women who take time off to visit a health facility. And men face social stigma if they undertake domestic work such as cleaning, washing or child care while their wife is away. Older women frequently view younger women seeking health services as a way of avoiding arduous and time-consuming domestic duties.

A Muslim women accompanied by her husband at Bheri Zonal Hospital

Women's work burdens were said to particularly impact the accessing of services that require multiple visits at specific times, such as child immunisation, and the use of temporary family planning methods. And heavy work increases women's risks of miscarriage, uterine prolapse and other health risks. About 10% of Nepalese women are affected by uterine prolapse that results in pain, embarrassment and gender-based violence and rejection by families and communities (MoHP et al. 2012).

> "Those services like immunisation, where there is a fixed date for seeing the health worker... make it difficult to manage health problems during peak working times."
>
> Female, Makawanpur

Many participants said that women's economic dependence on their husbands limits their abilities to make decisions for themselves. The associated costs of transport and medicines when visiting distant health facilities make it imperative for such women to receive funds from husbands to attend. This financial dependence constrains them from independently accessing services they want for themselves and their children.

COMMUNITY BASED BARRIERS

The study also found that women's use of public spaces is controlled by household members and local communities and is linked to social, cultural and religious beliefs that vary by social group. All the study groups seek to control women's movements outside the home to demonstrate women's adherence to social norms and earn family prestige; to reduce the perceived risk of sexual infidelity; and for security reasons. The consequence is that women need to be accompanied by their husbands or a sanctioned family member when visiting a health facility. Community members reinforce these norms and expectations by gossiping about women who attend health facilities unattended, particularly in the Tarai where social controls are tighter and privacy less.

Women of different social groups experience additional constraints at the community level; for example, Dalit women experience caste-based discrimination, while ethnic group women experience barriers caused by cultural practices and language issues. Muslim women experience religious constraints. Briefing note 2 discusses these issues in more detail.

JOURNEY BARRIERS

Many women reported that social controls and norms concerning women's mobility impede their own and their children's access to health services as they need to be accompanied by their husband or a family member to visit a health facility. Issues of security and protection for women during journeys are also a huge barrier. Most women's lack of their own source of cash to pay for transport or to buy snacks also inhibits their use of health services. Bringing services closer to home to reduce the time and opportunity costs of journeys and to ease social approvals can assist in improving the access of poor and marginalised women to health services.

SERVICE RELATED BARRIERS

The social pressures on women to be shy or submissive in the home and community affect their self-confidence to seek health services, and was found to be particularly strong amongst Muslim and younger newly married women. Shyness in seeking health services from health workers of the opposite sex was reported by women at all study sites and by men for family planning services.

> "A local Chepang man married at 18 to a girl of 16. Now they have six children. Last year, she went to the health post to vaccinate her child with a man from the same locality who was also going for his son's vaccine. They went together to hospital. After immunisation, the two had *khaja* (snacks) together. A man from the same community saw them and reported to the husband about it. The husband could not control his fury and at her arrival, battered her cruelly to wounds."
>
> Female, Dhading

Women experience shyness when asked to reveal their bodies to male health workers and expressed concerns about being touched by male health staff. This leads to anxiety among women and their husbands, who fear community members may hear about social norms being broken. Shyness was also said to affect men's health-seeking behaviour, as they feel shy about asking female health staff and female health volunteers for condoms.

"Most men and women are not taking health services like family planning and safe abortion service because they are shy to talk to the other sex."

Female, Doti

"Even though husbands and mothers-in-law ask them to go, women feel shy to show their secret organs to someone. It is better to just die at home."

Female, Dhading

A husband giving medicine to his wife, Bheri Zonal Hospital

4. How to foster more partnerships between government agencies and civil society organisations to i) address the barriers that women and children, especially those from poor and excluded backgrounds, face accessing health services and ii) support women's economic empowerment?
5. How to build on successful social mobilisation initiatives, such as MoHP's Equity and Access Programme, which is implemented through women's groups, to support women's empowerment and behaviour change?
6. Can training, supervision and monitoring inputs be provided to strengthen the interpersonal communication skills of health workers and their motivation to be change agents? Improved communication and the counselling of women and their families, particularly from poor and excluded backgrounds, can influence and enable women to access services.
7. Can health services be delivered in more respectful and gender- and culturally-sensitive ways? This would include increasing the availability of female service providers, improving privacy for women undergoing consultations and examinations, providing services closer to home and eliminating gender and social discrimination in service delivery.
8. How can gender monitoring and auditing be strengthened at national, district and facility levels to maintain the spotlight on affecting gender norms and practices in homes, communities and facilities?

ISSUES TO CONSIDER

1. Can a holistic behaviour change communication approach be developed and implemented that targets different genders, generations, and household members to change the social norms and practices that hinder women and children's access to health services?
2. How to foster political commitment and support at all levels to address the social and cultural beliefs that hinder access to health services?
3. What can be done at the policy level to change social norms in the home to enable the greater use of health services by women and girls?

REFERENCES

MoHP, New ERA, and ICF International Inc. (2012). *Nepal Demographic and Health Survey 2011*. Kathmandu: Ministry of Health and Population, New ERA, and ICF International.

Thomas D et al. (2012). *Voices from the Community: Access to Health Services: A Rapid Participatory Ethnographic Evaluation and Research (PEER) Study, Nepal.* Kathmandu: Ministry of Health and Population and Nepal Health Sector Support Programme.

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