Gender Inequality in Access to Health Services in Pakistan - 60988

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Public Policy Challenge

Equality is one of the core values of UN Millennium Declaration, the statement, which became the basis of principles underlying Millennium Development Goals (MDGs). Both international treaty standards and human moral perspectives obligate addressing inequalities. The United Nations Millennium Development Goals (MDGs) number 3 and 5 are about women empowerment and health. Goal number 3 is about gender equality and women empowerment, while goal number 5 asks for endeavors to improve maternal health.MDGsthemselves highlighted some aspects of inequality, especially, gender inequalities in health, education, and employment. Progress in removing inequalities in all these areas is very slow in Pakistan. Half of Pakistan's 184.35 million people consist of women population (Economic Survey 2013-14). Majority of the population lives in the rural areas with limited basic facilities. Evidence suggests that gender inequalities have resulted in devaluing of and indifference towards women health issues (Fikree and Pasha 2004).

Adequate and easily accessible health services to women population in Pakistan poses a serious public policy challenge. Maternal mortality rate is 260 per 100000 live births (Economic Survey 2013-14). Antenatal care coverage is 61 per cent (WHO 2014). Services of skilled health personnel are available to only 39 per cent of women (WHO 2014). Infant mortality rate is 69.3 per 1000

live births. Only 6 nurses are available for 10000 people (WHO 2014). Availability of Primary Health Care Units is 8 per 10000 people. Comprehensive Emergency Obstetrics and Neonatal Care (EmONC) is available in 275 hospitals/facilities in the country. Basic EmONC is available in 550 hospitals/facilities (Economic Survey 2013-14).

A variety of factors, such as socio-cultural trends, economic condition, administration style, and historical trends, have been identified for this state of affairs. Mumtaz et al (2003) have identified restricted mobility and cultural barriers in male-female interaction as the key factors for lower health outcomes among women. Pakistani society is patriarchal, with clearly defined gender roles. A feudal socio-political system creates inequalities in distribution of land and other resources. Gender disparity thus created results in delay in treatment seeking amongst women, which has affected the health of women in Pakistan. Cultural barriers have limited women access to the outer world. It is becoming a very serious issue, particularly, for the unmarried women. Men control all the resources, so they take health related decisions for women (Shaikh and Hatcher 2005). Women's role is to look after the children and perform other household duties. These socially constructed roles for men and women have contributed largely to the growing problem of inequalities in access to health services.

In terms of availability of resources for the health services, health expenditure as percentage of total government expenditure stands at 3.6 per cent. Health expenditure as percentage of GDP is a merely 2.5 per cent (WHO 2014). Limited resources necessitate better management of the health service delivery closer to communities. There is shortage of female doctors, which keeps

many women away from the hospitals. Unskilled midwives attend women at home during childbirth. Female doctors are available in 41.8 per cent of the facilities (Ali et al 2008). Family planning and reproductive health clinics are accessed by 10 per cent only. Distance of health facilities is an important factor, which impacts health-seeking behaviour. Health related decisions are influenced bydistance of health facility, cost to reach there, and time taken to visit these facilities (Shaikh and Hatcher 2005). Long distance is considered a disincentive for women, who will need somebody to accompany them. History of authoritarian military regimes, highly centralized public administration, and rigid civil service structure have also contributed towards poor health outcomes (Bossert and Mitchell 2010). Provincial governments have always shown reluctance to transfer powers to the local levels. They controlled everything from policy making to petty purchases. Lack of accountability at the local level allowed local health officials to indulge in corrupt practices, which resulted in inadequate medicines, staff absenteeism, and poorly run health facilities.

Underlying Assumptions And Elements Of The Policy Response

Cultural, economic, administrative, and social factors are responsible for gender inequality in access to health services. The policy makers were mindful of these barriers that prevented equal access to health services. They acknowledged that socio-cultural values could not be changed overnight. These values and traditions are deeply rooted in peoples' way of life. Social transformation takes time and consistent effort. Women form half of Pakistan's population. Their health related needs cannot be left unaddressed. Health

indicators for women and children were showing little progress. In the rural areas the figures showed declining health outcomes for women. Health service delivery was also not catering for the needs of women. Having acknowledged these facts, the policy decision-makers decided to formulate a policy that would address women health issues, while keeping in view the socio-cultural sensitivities of the people.

The new policy was based on certain assumptions. First, it assumed that since women have cultural and mobility issues to access health services, therefore, taking the health services to their doorstep will address their mobility problem and their male family members will have no objection to their women being treated by women health workers in the safety and security of their own homes. Second, provision of basic health services to all the women will effectively address the equity issue. As the program expands its coverage, equal access to health services will be achieved for women. Third, policy makers borrowed the idea of devolution of powers to local levels and local accountability from Western Governance framework. It assumed that the government is willing and ready to transfer powers to the local level, so that Basic Health Units (BHUs), and Rural Health Centres (RHCs), which were the cornerstone of the new policy, can be run with the active involvement of the local community. It also assumed that public is aware of the value of transparency and accountability, an idea borrowed from Governance framework. This assumption of government's willingness and readiness to transfer power, and people's awareness about transparency and accountability was based on the distinctive features of the new Devolution Plan (2000) that was to transfer substantial administrative and

financial powers to local governments. Last, the new policy relied heavily on the support and involvement of the people. It assumed that people knew their interest and would support government's initiative. People would be willing to participate in the process and would shoulder the responsibility of their local affairs.

The Policy Response

It is quite ironic to note that the policy to address inequalities in access to health services and to transfer comprehensive administrative and financial autonomy to the local levels was introduced under the military rule of President Musharraf. The devolution Plan of 2000 was a comprehensive program to devolve powers to the grassroots level. The devolution plan created three tiers of local governments: District, Tehsil, and Union Council. Union Council was the lowest tier, which was created at the village level. District governments were responsible for their own development strategies, programs, and interventions according to their local needs. A comprehensive health policy was also formulated as part of the Devolution Plan. Under the new health policy, primary health care became the central point of all health initiatives.

The Ministry of Health started Lady Health Workers (LHWs) program at the community level. These were community based female health workers who were recruited from the same communities where they were assigned duties. Similar programs had produced positive results in Bangladesh, India, and Nepal (Mumtaz et al 2003). The focus of LHWs program was on maternal and child

health including family planning. Initially, 40,000 Lady Health Workers were deployed in villages and in some selected urban centres. Each LHW covered a population of around 1000. The program was started in all the districts of Pakistan. The Lady Health Workers visited homes and provided basic maternal and child health care to women. Through a referral system, women were sent to other health facilities for further treatment, if required.

A second cadre of female community based health workers was Village Based Family Planning Workers (VBFPWs). The Ministry of Population Welfare started this program. These female health workers provided family planning information and services by visiting homes in their assigned areas. These workers were also locally recruited. Initially, 10,000 of such workers were recruited (Shaikh and Hatcher 2005). Recruitment criteria for both LHWs and VBFPWs were 10-12 years of schooling and local residency (Mumtaz et al 2003). Government established training colleges to provide training to LHWs and VBFPWs. Later both the LHWs and VBFPWs programs were merged together.

An elaborate network of Basic Health Units (BHUs) and Rural Health Centres (RHCs)provided support to these female health workers. BHUs served a population of 10,000-20,000, and RHCs a population of 25,000-50,000. The next level was Tehsil (or sub-district) hospital serving a population of 0.5-1 million (Shaikh and Hatcher 2005). Above this level came District Headquarters hospital (DHQ) and tertiary level hospitals. The BHUs and RHCs had female staff so that women could consult them without any hesitation. This conformed to the local culture and traditions as well. Administratively, the local government ran BHUs

and RHCs. They had substantial administrative and financial autonomy. District government was empowered to purchase medicine and other equipment for those BHUs and RHCs. Local population was involved in the running of those facilities through local level councils and citizen bodies. There were local committees that oversaw the purchase process and ensured transparency.

This network, which starts from the LHWs and ends at tertiary level hospitals, is designed to focus on primary health care, especially maternal and child health. It serves the health related needs of the local population, while respecting local culture and traditions. Women are provided health services within the comfort of their homes. BHUs and RHCs are established to deal with cases that cannot be handled by LHWs. This policy helped in reducing maternal mortality rate, improving access to reproductive health services, provision of health services closer to communities, vaccination of infants, after birth care, and effectively addressed the equity issue. The policy was successful because it was sensitive to the local culture and social limitations. It was a nice blend of western governance practices and local cultural needs. The policy took the health services, literally, to people's doorsteps.

Analysis of the Policy

The policy was very successful in the initial years of its implementation. It established local democratic structures and involved local population in the decision making process, which made the public service delivery more responsive to local health needs. LHWs and VBFPWs provided health

information and services to women through their home visits. These female health workers were local residents, so people knew them and trusted them. However, some flaws in the policy were highlighted during its implementation:

1. Change of government had a negative impact on the program. New government was not interested in giving enormous administrative and financial powers to the local governments. As typical to Asian countries, politicians and bureaucrats wanted to concentrate powers in the central government authority, be it Federal government or Provincial governments. The powers of district governments were cut down through legislations and district governments were made dependent on provincial health department for their purchases. Under the new legislation medicines and equipment were purchased by the central government and distributed to BHUs and RHCs according to their needs. It created delays and purchase of unneeded items. Recruitment, training, and other service matters are now controlled by the central government, which makes it very difficult for the female local workers to visit the central offices to redress their service related grievances.
2. Another flaw in the policy is inadequate training for the LHWs. Most of the LHWs were locally recruited and had very little education. Government at that time wanted to introduce the new policy in earnest, that is why it could not design a comprehensive training program for the LHWs. There was no system of in-service or on-job training. Most of the LHWs were not qualified to handle

serious cases or provide first aid. It resulted in large number of cases referred to DHQ and tertiary level hospitals. The male members of the family would not allow their women to visit these hospitals due to cultural constraints.

3. BHUs and RHCs have restricted hours of operation. In case of emergency, people have to travel to cities, which sometimes prove fatal for the patient. BHUs are located at a distance from the community. The location of BHUs is very important to address the mobility issue for the women. Due to socio-cultural constraints, some male member of the family needs to accompany the women to visit these facilities. The distance poses a grave challenge, especially for the unmarried women. Dearth of transport facilities, cost of travel and time taken to visit the facility influence women's behaviour to seek health services (Shaikh and Hatcher 2005). Lack of mobility for women results in gender inequalities in access to health services.
4. Many positions of qualified female medical officers remained vacant at BHUs and RHCs. Only 25 percent of BHUs and RHCs had qualified female health providers (Shaikh and Hatcher 2005). No female doctor wanted to serve in rural health facilities. The government did not offer any incentive to them to work in the rural areas. Most of the female staff, including doctors and nurses remained on long leave. Absence of female staff from BHUs and RHCs kept the local women away from these facilities, as their male members of the family did not allow treatment from male

health service providers. The result of unavailability of female health service providers is that women are now provided health services only in emergencies. They rely on traditional healers and herbal medicines for their day-to-day health related needs.

5. It is important to note that LHWs and VBFPWs operate within "the same gender systems that necessitate their appointment in the first place" (Mumtaz et al 2003:261). These female health workers were locally recruited, but they had to face same cultural constraints as their patients. Many of them had very little education and joined the service out of economic compulsions. Bossert and Mitchell (2010) studied the working conditions in which LHWs operated. They have reported that these female health workers identified disrespect from male colleagues, abusive hierarchical service structure, conflict between domestic and official duties, and lack of sensitivity on the part of male members of the household they visited, and poor infrastructural support as the main problem areas in the delivery of their services. They have also reported that husbands of the women they visited did not give them proper respect and considered them as loose character. Many female health workers had to quit their jobs under pressure from male members of their own family. These socio-cultural constraints made many LHWs leave their job, which created a huge gap between demand and supply of health services to women.
6. Transport remains a problem for the female health workers. These workers have to go on foot from house to house. A Lady Health

Worker covers more than one village. Villages are located at a distance from each other. These workers use local transport to travel from one village to another. Their salaries are meager and transport cost is an additional burden on them, which makes the job very unattractive for them.

7. Lastly, corruption and irregularities in purchases at the local BHU level are becoming routine matter. Due to local officials' corrupt practices; these health facilities are usually short on medicines. The equipment is not in working condition. Furniture is mostly broken. Budget is spent on salaries and travel expenses. It is because there is no proper monitoring and evaluation mechanism. The reports sent to the Health department are mostly based on fabricated figures. In most of the cases BHUs are without medicines and staff.

Recommendations

The problems of the policy discussed above are cultural, social, and administrative. The LHWs program has successfully addressed the issue of gender inequality and women health related needs to a large extent. The policy drew upon key aspects of Western governance framework, such as devolution of power to local levels, government's responsiveness to peoples' need, local accountability, and peoples' participation in service delivery. This foundation provided the locally relevant superstructure of primary health care that included LHWs BHUs and RHCs. First of all government needs to re-introduce Devolution Plan by transferring comprehensive administrative and financial powers to local

levels. Second, basic criterion for the recruitment of LHWs needs to be changed. Science graduate women should be recruited as LHWs and VBFPWs, so that they could give proper advice to women regarding maternal and childcare. The training program should be based on the common disease pattern, emergency response, common weather related problems, communication skills, and self esteem. Provision of transport facility is important to improve their mobility so that they could visit more homes in less time. Third, female medical officers should be posted in all BHUs and RHCs. These doctors should be given incentives to work in the rural areas. Without the female doctors, BHUs and RHCs have no utility for the female population. Fourth, BHUs should be located closer to communities. Distance is an important factor in the female mobility. Nearer the health facility, more likely it is for women to seek health related help. Fifth, a proper monitoring mechanism should be developed to check corrupt practices in the BHUs and RHCs. This will ensure availability of staff, medicines and working medical equipment. Sixth, it is very important to design and run an awareness campaign about the role of LHWs in providing health services to women in their homes. Lady Health Workers' services should be recognized at the highest level. It will help remove some of the gender related obstacles in the discharge of their duties. Cultural change cannot happen overnight, but effective policies and consistent effort can help change attitudes towards women access to health services and female health workers.

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