Access to Quality Gender-Sensitive Health Services
Women-Centred Action Research

The Asian-Pacific Resource & Research Centre for Women
Textiles and women’s lives are intricately weaved together. Across disparate cultures and time zones, women weave cloth, interpret stories on fabrics and use textiles in ingenious ways. A woven cloth is wrapped round the body, for protection, for modesty or to carry babies. Fabrics from the six countries in Asia featured in the case studies, each with its own distinctive design and women’s stories to tell.
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List of principal researchers

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- Dr. Kaosar Afsana and Sabina Faiz Rashid from the Bangladesh Rural Advancement Committee (BRAC), Bangladesh;
- Dr. Fang Jing, Deputy Director, Yunnan Reproductive Health Association (YHRA), Kunming, China; Xiong Qiongfen; Shi Zhenli; Guo Jimei; Zhang Jianping; Xiao Xia; (China);
- Dr. Wong Yut Lin, Health Research Development Unit (HeRDU), Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia;
- Hilda Saeed and Fauzia Rehman, Shirkat Gah, Karachi, Pakistan;
- Rosena D. Sanchez and Dr. Regina P. Ingente, Ateneo de Davao University, Philippines;
- Dr. Kamini Alahakone, Dr. Ranjit de Alwis, Thana Sanmugam and Varuni Sumathiratne, Centre for Women’s Research (CENWOR), Colombo, Sri Lanka.

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The following ARROW team worked very hard on the project.

- Rashidah Abdullah, Project Director
- Geeta Nanda – intern
- Vanitha Subramaniam, Programme Officer from August 1997 – June 2001
- Elaine Tan, Project Manager, 1999 – October 2002
- Liow Moi Lee, Manager
- Meena Shivdas, Editor
- Rathi Ramanathan, Programme Officer
- Lim Bee Ling, Copy Editor
- Manimekaladevy Navaratnam, Secretary
- Khatijah Mohd Baki, Assistant Administrative Officer
- Norlela Shahrani, Administration Manager
- Uma Thiruvelogam, Assistant Programme Officer (IDC)
- Syarifatul Adibah, Assistant Programme Officer (IDC)
- Shanta Anna A. Vincent Pillay, Assistant Administrative Officer

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List of Principal Researchers

Bangladesh

Dr Kaosar Afsana
Senior Medical Officer
Research and Evaluation
BRAC Centre
75 Mohakhali C/A
Dhaka – 1212
Bangladesh
Tel: 880-2-8841807 (office)
Fax: 880-2-836769 (residence)
E-mail: imitiaz@bracmail.net or
bracamr@bdmail.net

Malaysia

Dr Wong Yut Lin
Health Research Development Unit
Dean’s Office
Faculty of Medicine
University of Malaya
50603 Kuala Lumpur
Tel: 03-7967 5728 (direct), 79675748 (general office)
Fax: 03-79675769
E-mail: wongyl@um.edu.my

Philippines

Rosena Sanchez
Social Research Office
Ateneo de Davao University
Davao City 8000, Jacinto St
Philippines
Tel (6382) 224-2955
Fax: (6382) 64116
E-mail: sro@addu.edu.ph or
rosena_s@yahoo.com

Sri Lanka

Dr Kamini Alahakoon
Centre for Women’s Research (CENWOR)
12 t/l, Ascot Avenue
Colombo 5
Sri Lanka
Tel/fax: 00 941 502828/941-502153

Pakistan

Hilda Saeed
D-77 Block 2, Clifton
75600
Karachi
Pakistan
Tel: (9221) 586 1319
Email: Hilda@cyber.net.pk

China

Dr Fang Jing
Yunnan Reproductive Health Research Association
650031 Kunming
Yunnan, China
Email: baoheng@public.km.yn.cn
Introducing the Regional Research Project

Rashidah Abdullah and Monica Jasis

INTRODUCTION

The Asian-Pacific Resource and Research Centre for Women (ARROW) is committed to supporting efforts in mainstreaming gender perspectives in health, population and reproductive health policies and programmes. One of ARROW’s strategies for policy advocacy is to build a body of knowledge on action research that focuses on analyses of health policies and programmes. ARROW therefore recognises the need for a stronger articulation, analysis and documentation of health issues by women’s groups. In accordance with these goals and based on the recommendations of the Beijing Platform for Action (Beijing PFA, section on Women and Health), ARROW developed this regional research project to assess women’s access to gender-sensitive health programmes and services. Funded by the UK Department of International Development (DFID) and the FORD Foundation, India office, the project began in December 1997 and was completed in 2001. The project examines health programme implementation and assesses the extent to which major governmental and non-governmental health organisations are addressing key factors such as affordability, physical access, gender-sensitive and women-centred quality of care in health programmes and services in six countries in the region.

This project constitutes an invaluable experience, not just for the researchers, but also because it is a pioneer effort for the Asian region. In many of the country case studies, it was the first time that women clients and service providers were actively included as research participants, rather than subjects. The project was unique not only for its use of qualitative methods for health research, but it also spawned advocacy tasks from the results of its findings.

The objectives of the study are based on the recommendations of the Beijing Platform for Action. In particular, the project plans to look at programme implementation and assess the extent to which major governmental and
non-governmental health organisations are operationalising the aspects of affordability, accessibility, gender-sensitivity, high quality and women-centred into their health programmes and services.

The Rationale

Women NGOs in Asia and the Pacific have for the last 15 years been advocating for the need for health programmes for women to be much more accessible, culturally sensitive, address gender issues and of a higher quality. However, indicators of health status in the region, especially in South Asia and poorer countries, still show unmet needs in the provision of basic primary health services, this includes the area of maternal health, which is a critical component of women’s reproductive health. Except for the few developed countries of the region, the life expectancy of women is relatively low, being only around 50 or 60 years. Moreover, deaths from pregnancy and childbirth (maternal mortality) are moderate to high ranging from rates of 100 to 800 deaths per 100,000 live births. These high rates of death reflect inadequate access to basic technology and health service infrastructure which could prevent such mortality.

Adequate service is also lacking in the expanded areas of reproductive health (for example, screening for reproductive cancers, sexually transmitted diseases, and HIV/AIDS), mental health and the health issue of violence. In most Asian and Pacific countries, the neglect of women’s health needs is often the result of narrowly conceived health programmes which mainly provide services directly related to maternal health and family planning. Current programmes that are available have been criticised for not taking into account gender issues. These include the effect of male dominance in decision-making related to seeking reproductive health care and an unbalanced contraceptive responsibility where women are expected to use contraception and bear the burden of this in terms of side effects and practice. Therefore, such health programmes reinforce stereotypes about men-women relationships and act as a barrier to women’s good health. Gender inequality does not give women and men equal status, rights and responsibility, and can therefore have a detrimental effect on women’s health, wellbeing and their overall position in society.

Beijing Platform For Action

The Beijing Platform for Action’s section on Women and Health acknowledges this situation and puts forward specific objectives and recommendations to be implemented primarily by government organisations. An overall objective defined in the Platform is:

- Increase women’s access throughout the life cycle to appropriate, affordable and quality health care, information and related services. (C 1. Pg. 41)

Twenty-five actions are then recommended including:

- Design and implement, in cooperation with women and community-based organisations, gender-sensitive health programmes, including decentralised health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands of their time, the special needs of rural women and women with disabilities and the diversity of women’s needs arising from age and socio-economic and cultural differences, among others. (Para. 106. C)

- Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user’s perspectives. (Para. 106. F)

- Ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women’s health services. (Para. 106. G)

However the Platform does not elaborate on what is meant by ‘gender-sensitive’ care. This is a new concept that emerged in the 1990s, but appears to have a number of meanings. ARROW’s regional research project in 1996, “Changes in Population Policies and Programmes Post-Cairo” which covered eight countries – China, Fiji, Indonesia, Malaysia, Pakistan, Singapore, Thailand and Vietnam – yielded some valuable findings regarding perceptions of women’s health services
and programmes in the region. Health and family planning policy makers and programme managers interviewed frequently, claimed their services were already ‘gender-sensitive’ and ‘accessible’ to women. Furthermore, on the issue of training on gender-sensitisation, only Pakistan mentioned an established training programme for health officials and providers in gender perspectives. The Post-Cairo study also indicated that in some countries, no gender analysis of programmes had been done, and little programme evaluation was done in general. One Pakistan interviewee stated that “…there is still no evaluation of our programmes at government level, neither positive nor negative”. In Indonesia, some NGOs and researchers stated that “efforts to include gender aspects in the issues of family planning and reproduction are invisible” and the focus is still on the role of women and family welfare rather than gender and individuals. The Malaysia report suggested that understanding of the concepts of ‘gender equality’ and ‘gender analysis’ was low among high-level government officials in health management. Indonesia reported that NGO perception of the terms ‘gender’ and ‘empowerment’ were used “without them knowing the real meaning”. The findings from the Post-Cairo project were important in shaping the objectives of the present study in terms of the need for a critical evaluation of current health programmes for women.

It was also assessed that there were hardly any tools to assist governments and NGOs to implement these Beijing recommendations, such as clear concepts on gender-sensitivity, affordability, and frameworks of criteria and indicators to use in guiding implementation and evaluating services. In addition, no current research initiatives in Asia and the Pacific were known at that time which addressed the need to evaluate health services and produce useful tools for monitoring. ARROW’s programme at that time aimed to re-orientate health policies and programmes to include women’s and gender perspectives through the strategies of research and evaluation, and the production and distribution of practical information and tools. The Cairo and Beijing Conference recommendations were an important context.

**Project Objectives**

Based on the needs outlined above and its programme mandate, ARROW designed the project on women’s access to gender-sensitive health services with the following specific objectives:

- To assess the progress and obstacles experienced by major governmental and non-governmental health organisations towards planning and implementing programmes for women which are:
  - affordable, accessible, gender-sensitive, of high quality, and women-centred (namely based on women’s needs and experiences); and
  - designed and implemented in cooperation with women and women’s organisations.

- To refine, develop and disseminate effective women's health programme research and evaluation tools which are gender-sensitive and women-centred.

- To encourage organisations in Asia and the Pacific to review their health programmes for women within the Beijing Platform for Action using appropriate frameworks, criteria and tools.

ARROW’s Resource Kit “Women-Centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women’s Health in Asia and the Pacific” produced in 1996, had several frameworks and tools on gender-sensitivity and women-centred health services which could be used as guides.

**PROJECT TEAM**

**Countries**

A research team was formed initially in eight countries (Bangladesh, Fiji, India, Indonesia, Malaysia, Pakistan, Philippines and Sri Lanka) as an outcome of identification of researchers and women NGOs in Asia and the Pacific who would be most committed to the objectives of this project. The plan envisaged that country research coordinators would ideally be researchers skilled in carrying out research or programme evaluation and active in the women’s movement or who share common values and goals. Other criteria were that the coordinator could be working with a women’s
health group involved in bringing about change, or linked with such an organisation for future action and advocacy (1997 Project Overview). Due to delays in funding confirmation, the Indian and Indonesian researchers did not continue as part of the team, and the Indian researcher raised her own funds. Chinese researchers joined the team in 1998 at the request of the new project funder. The Fijian team, meanwhile, participated in the project but did not complete the research due to problems related to the political situation in the country.

A total of 23 researchers from ten Asian and Pacific countries contributed to this project, either directly as researchers, consultants or resource people. The principal researchers and the broader research team were social and health scientists working in universities, as research consultants, or in NGOs. Academic researchers all had organisational involvement with women NGOs involved in women’s health and rights.

Researchers

- Dr. Kaosar Afsana and Sabina Faiz Rashid from the Bangladesh Rural Advancement Committee (BRAC), Bangladesh;
- Rosena D. Sanchez and Dr. Regina P. Ingente, Ateneo de Davao University, Philippines;
- Dr. Wong Yut Lin, Health Research Development Unit, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia.
- Dr. Kamini Alahakone, Dr. Ranjit de Alwis and Varuni Sumathiratne, Centre for Women’s Research (CENWOR), Colombo, Sri Lanka;
- Hilda Saeed and Fauzia Rehman, Shirkat Gah, Karachi, Pakistan; and
- Dr. Fang Jing, Yunnan Reproductive Health Association (YHRA), Kunming, China.

Consultants and Resource People

- Dr. Monica Jasis, Centro Mujeres A. C. Mexico and also the Latin American and Caribbean Women’s Health Network, was a resource person for the Planning Meeting, and consultant for two Researcher’s Meetings.
- Dr. Sundari Ravindran, Rural Women’s Social Education Centre (RUWSEC), India, the consultant for the Planning Meeting;
- Dr. Lynne Hunt of Edith Cowan University, Perth, Australia, a resource person for the Planning Meeting; and
- Dr. K. Tint, South Africa Women’s Health Policy Project, a resource person for the Planning Meeting inputs.
- Dr. Margaret Chung and Saloma (Fiji); Dr. Leela Visaria (India); Anna Marie Wattie (Indonesia); Dr. Pimpawun Boonmongkon (Thailand); and Muna Thapa (Nepal) contributed ideas and research experiences in at least one of the three Researcher’s Meetings.

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- Rashidah Abdullah, Project Director
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- Uma Thiruvengadam, Assistant Programme Officer (IDC)
- Syarifatul Adibah, Assistant Programme Officer (IDC)
- Shanta Anna A. Vincent Pillay, Assistant Administrative Officer

PROJECT IMPLEMENTATION

The project was conceptualised, researchers, resource persons and consultant identified, and a Planning Meeting was held in Kuala Lumpur in
December 1997. At this meeting, Dr. Sundari Ravindran, the research consultant, and three international resource people, shared their individual and organisational action-research experiences, and resources and tools on access to gender-sensitive quality health care. These included the inspiring examples of the Women’s Health Policy Project of South Africa, in particular, the participatory action research project, ‘Transformation of Reproductive Health Services’; Consumer Health Research of General Practitioners in Australia; several studies in Brazil, Chile and Mexico of the Latin American and Caribbean Women’s Health Network on gender-sensitive quality of care; and the experience of the Rural Women’s Social Education Centre (RUWSEC) in Tamil Nadu, India, of community-based women’s groups monitoring health care services. After discussion on the research framework and methodologies, the researchers developed and presented their preliminary research plans.

Research was conducted in Bangladesh, China, Fiji, Malaysia, Philippines, Pakistan and Sri Lanka from the period of 1998-2001. Research reports were finalised and a Researcher’s Meeting was held in Kota Bharu, Kelantan, Malaysia, in November 2000. A preliminary analysis of overall findings was made. Discussion of the findings and a third Researcher’s Meeting was held in Khon Kaen, Thailand, in July 2001. Advocacy activities were organised in countries and internationally to discuss and disseminate the findings. In 2002, the publication was prepared.

**SPECIFIC RESEARCH OBJECTIVES**

During the initial Planning Meeting in December 1997, it was agreed that the research would have the following specific objectives.

**Long-term Objective**

The long-term goal is to effect changes in the perception of health service providers and in women’s knowledge of their rights to quality health care services such that there is improved and more gender-sensitive provision of health services for women in Asia and the Pacific.

**Immediate Objective**

To assess low-income and/or otherwise marginalised women’s access to gender-sensitive, quality health care services in the selected countries.

**RESEARCH PRINCIPLES**

In the 1997 Planning Meeting, participants agreed on the main principles of the research.

**Action-oriented**

The research would focus on bringing about change as an immediate outcome of the research process, by utilising opportunities for intervention with service providers and women clients themselves. Findings would also be used for the advocacy of better health services for women. Part of the research funds was allocated for this action component.

**Women-centred**

The research would focus on women’s needs and experiences of health services as articulated by the women themselves. This necessitated research methods and processes to ensure that women had the opportunity to express their concerns and that these were listened to, understood and the needs responded to appropriately. In measuring women-centredness, the diversity of women would be acknowledged and include unmarried and married women, older and younger women, poorer and richer women. Informed consent, confidentiality and privacy would be methodological concerns based on the respect for women’s needs.

**Participatory**

The research process would engage the stakeholders in becoming active participants in the planning, implementation and evaluation of the research. The stakeholders were women clients, service providers and the management of the organisation.
Gender-sensitive

The research would be implicitly and explicitly gender-sensitive in the analysis of the different needs, identity and behaviour of women and men as a result of their unequal social relations. The distinct differences in the way women experience health services due to their social relations with men would be analysed.

CONCEPTUAL FRAMEWORK

Concepts/Definitions

The key concepts were defined at the Planning Meeting.

Accessibility of health care services was defined as being broader than geographical or physical access. Accessibility in the research context include the question of affordability, access to good care, diagnosis and screening. It also included policies that are gender-sensitive and enhance women’s access to quality health care services.

Quality of care was defined as a combination of both technical competence and infrastructural quality; and gender-sensitive provision of services was defined by what women want and need, and by an understanding of the impact of gender relations of women’s access to quality health care. In such a definition, the availability of services and facilities would be as equally important as a dignified interpersonal relationship between service providers and clients.

Women-centred was understood as focussing on women’s needs and experiences as articulated by the women themselves. As described in Tool No. 5 of the ARROW Resource Kit, “Women-centred means that the needs, values, information and experiences and issues from the point of view of women are considered and incorporated in the planning, implementation and evaluation processes of policies and programmes which effect women’s lives. It is essential that mechanisms are built into the [research] processes to ensure that women are able to articulate their needs and that these are listened to, understood and that there is a concrete response or change”. Throughout the research process, it was considered essential that a diversity of women were included, both married and unmarried, both older and younger, and both rich and poor.

Gender-sensitivity was defined as the understanding of different needs, and identifying behaviour of women and men as a result of their unequal social relations. This inequality further resulted in distinct differences in the way that women and men, albeit from the same social, economic and political status, experience health services. It was noted that many times there are social and cultural factors that have little to do with actual physical barriers (such as distance, income levels, treatment by service providers etc.) that affect women’s access to quality health care. These may stem from the social and cultural conditions in which women live that are different from the experience of men.

Central Research Questions

Four research questions provided a broad framework for the research focus.

- What do disadvantaged/or marginalised women through the various stages of their life cycle, need, want and feel a right to, in terms of their access to comprehensive quality health care which is gender-sensitive? (The group distinguished the difference in women’s ability to articulate their needs when they have knowledge of their rights.)

- To what extent do women have access to the health care services that they need and want?

- What are the main barriers and solutions to women’s accessibility to gender-sensitive quality health care?

- What are the commonalities and differences in the perceptions of women and health care providers on the issue of needs, access, barriers to access and solutions to overcome barriers?
Conceptual Matrix

A matrix which was adapted from the Latin American research project. It was presented at the Planning Meeting to guide the individual research case studies. It was understood that this was just a guide that could be adapted to meet different country, organisational and cultural contexts.

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>Gender-sensitive</th>
<th>Women-centred (based on women’s needs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of care/ Follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This initial matrix was modified and expanded for the comparative analysis of findings during the subsequent two Researcher’s Meetings. This is presented in the chapter on tools.

The research methods considered were:
- Autobiographical/ Life history approach
- Participatory involvement of service providers
- Developing a community-based core group to guide the research process
- In-depth interviews with women clients and service providers
- Participant observations
- Checklists for technical and infrastructural competency
- Exit polls/Interviews
- Questionnaires and surveys
- Focus group discussions

HEALTH SERVICES STUDIED

Country researchers designed their projects guided by particular concerns of their countries.

Bangladesh has a high rate of maternal mortality and morbidity. BRAC is a national NGO that provides services that contribute to reducing those problems in the community. These services were the research focus of Kaosar Afsana and Sabina Faiz Rashid.

According to Fang Jing and her colleagues, Yunnan Province in China shows extremely low utilisation of government services for reproductive tract infections (RTIs) by women users. They studied the constraints for utilisation of services, including poverty, lack of knowledge and information on RTI services at the community level.

In Malaysia, while women suffer inequalities in health care status, the health care system remains insensitive to women’s health needs, as providers lack the understanding of the principles of gender equity. Non-governmental organisations are identified as the only services committed to responding to the reproductive health care needs for the community. However, in the rural state of Kelantan, the family planning users’ rate is low. Yut Lin investigated many aspects of service delivery as well as how socio-cultural beliefs impact the use of those services.

For Kamini Alahakone from Sri Lanka, the health of women workers from the export-based industry (free trade zone) and the health services’ response was key to her study. Women in the country had available reproductive health programmes but these facilities had not been evaluated although factories employ thousands of women.

To confront the poor economic, social and health status of women in Pakistan, the Ministries of Health and Population Welfare started a collaborative programme to integrate women’s access to health care. Shirkat Gah from Pakistan sought to investigate different aspects of this programme.
Rosena Sanchez and Regina Ingente suspected that in the Philippines, women might have specific reasons for choosing a large urban medical centre for their reproductive needs instead of alternative services, this is in spite of supply shortages, inadequate facilities and doctors with high workloads and problems in dealing with their patients.

Of the research studies in the six countries, four studied government health services, two NGO health services, and one, a mix of government and private sector services. Four focused on reproductive health services and two on primary and general health services. The scope of the research is given in Table 1. Although all research studies attempted to address the specific research objectives and the research questions, there are differences in focus and research designed according to national realities on women’s health, organisational needs and the researcher’s own interests.

### Table 1: The Scope of Health Services Studied

<table>
<thead>
<tr>
<th>Country</th>
<th>Organisations/Health Service</th>
<th>GO or NGO</th>
<th>Specific Services</th>
<th>Issues of Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>BRAC (Bangladesh Rural Advancement Committee) Health Centre – one centre</td>
<td>NGO</td>
<td>Maternal care/childbirth services</td>
<td>Access and utilisation</td>
</tr>
<tr>
<td>China</td>
<td>Government primary health services (three clinics) - Rural</td>
<td>GO</td>
<td>Reproductive Tract Infection Services</td>
<td>Access and utilisation</td>
</tr>
<tr>
<td>Malaysia</td>
<td>Rural State Family Planning Association Services (four clinics)</td>
<td>NGO</td>
<td>Family planning and reproductive health services</td>
<td>Access and utilisation; Islam and contraception</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Government primary health services, two provinces of Sindh and Punjab (14 facilities) – Urban</td>
<td>GO</td>
<td>Primary health services</td>
<td>Access, utilisation, reproductive health and integration</td>
</tr>
<tr>
<td>Philippines</td>
<td>Government hospital</td>
<td>GO</td>
<td>Gynaecological and childbirth services</td>
<td>Access and utilisation</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Government and private health services in a free trade zone (two government and three private services)</td>
<td>GO and private sector</td>
<td>Health services for women factory workers</td>
<td>Access, utilisation, women’s health needs</td>
</tr>
</tbody>
</table>

**RESEARCH METHODS AND TOOLS**

In order to carry out research studies in congruence with the agreed research principles, qualitative research methods were used. These enabled better understanding of women’s needs and realities and ensure that the research was women-centred. The researchers felt it was essential to have a qualitative approach in order to be able to listen to voices of women and their own expressions of perceptions, needs, feelings and complaints, as well as women’s subjective meanings within specific environments and situations.

**Research Subjects**

All of the country researchers interviewed women as well as health providers in order to have direct information about health care. However, as all of the
researchers wanted the results of the studies to be tools for changes in public policy, most of them included interviews of key informants, primarily people in management positions.

Each research team developed its own tools including the use and adaptation of tools shared in the planning meeting by the resource group and those identified by ARROW through the information search.

**In-depth Interviews and Focus Groups**

All research studies used in-depth interviews with women clients, either in the health service facility or in their homes. A total of 160 women were interviewed. Seventy-five health service providers were also interviewed in five of the six studies. Three of the six studies organised focus group discussions. There were a total of 12 focus group discussions for women. While all of the researchers applied qualitative methods, Sri Lanka and Pakistan used both qualitative and qualitative methods.

**Other Methods Used**

- Self-administered questionnaires (one research study, involving 431 factory workers, 15 doctors and nurses and some management officials)
- Informal discussions (three studies)
- Facility checklists (four studies)
- Observations (four studies)
- Documentary reviews (two studies)
- Key informants (one study)

**The Action Component**

The project activities and budget included activities during and at the end of the research to discuss research findings and to develop recommendations for action which would improve women’s access to health services. This methodology was followed in five of the six case studies as shown in the following summary. A total of 10 workshops and three meetings with health providers were conducted by five of the six country researchers.

**LIMITATIONS OF THE RESEARCH**

As a qualitative research study, the number of women, and service providers interviewed in depth was small. In some of the case studies, the number of health service outlets was small compared to the number of outlets of the organisation. The findings therefore cannot be generalised. They need to be seen as case studies of specific health services and systems, which can provide insights into the needs of women for quality gender sensitive services and the barriers that exist which limit women’s access.

**NOTES**


Women’s access to gender-sensitive reproductive health services at the Kelantan Family Planning Association (KFPA), Malaysia

Wong Yut Lin

INTRODUCTION

The study investigates the reasons for the decline in new clientele for the Kelantan Family Planning Association, and asks if Islam plays a role in hindering women’s access to reproductive health services. Kelantan, a state located in northeast Peninsular Malaysia, is governed by the opposition fundamentalist Islamic party (PAS) and demonstrates contrasting gender and development trends. While there is widespread poverty with high numbers of maternal deaths among Malay/Muslim women and a low rate of contraceptive prevalence, women are also able to make autonomous decisions as entrepreneurs. However autonomy in one aspect of public life does not necessarily mean that women are able to make decisions in their private lives. At the policy level, the understanding of concepts such as gender equality and gender analysis are inadequate despite policy makers’ contention that the health system is gender-sensitive.

The Kelantan Family Planning Association (KFPA), established in 1957 and affiliated to the Federation of Family Planning Associations, Malaysia (FFPAM), operates three stand-alone clinics in the state and runs a mobile clinic at specific sites. As KFPA had reported a decline since 1997 in women’s access to family planning services despite having dedicated staff and committed management, a study exploring factors affecting access to reproductive services is timely. The study sought to find out whether the low access of KFPA services was a consequence of gender-insensitivity in services and whether the politico-religious setting of Kelantan was an inhibiting factor. Questions were raised on women’s access and the gender-sensitivity of the care provided. The enquiry employed qualitative methods of data collection that placed women’s perceptions and experiences at the centre of the analysis and was guided by principles of participatory, action-
oriented research. Information from 47 women (users and non-users) and 13 health care providers at the four operational clinics of KFPA formed the empirical basis for the analysis.

The study aims to:

- assess the extent to which KFPA addressed issues of access and gender-sensitivity in the quality of care delivered at its clinics by examining programmes and reviewing progress;
- explore women’s perceptions and experiences of KFPA services to determine if programmes and services were designed and implemented in cooperation with women and women’s groups; and
- influence changes in KFPA programmes as an immediate outcome of the research process that will strengthen the capacity of health service providers and empower women users.

This research is significant as the overall contraceptive prevalence rate is relatively low (below 50 per cent) and the common misconception that women aged 40 years and above are no longer fertile, leads to this cohort of women not practising contraception. Many of these women tend to be Muslim. It is hoped that this study will contribute to an understanding of factors that influence women’s reproductive health-seeking behaviour and enable KFPA to effectively meet the needs of Kelantan women.

**CONTEXT: MALAYSIA, KELANTAN AND KFPA**

**National**

The 1998 national demographic profile showed that out of a total population of 21.3 million, 35 per cent were under 15 years, 61 per cent were within 15-64 years, and the remaining four per cent aged 65 and above (Vital Statistics Malaysia, 1998, p. 15). The sex ratio for all ethnic groups and in all states with a few exceptions was higher for males than females, from the mid-1980s up until the early 1990s because of internal movements across states for economic reasons and the influx of foreign workers in cities (Wazir, 1996).

The 1992 sub-national population survey showed a marked trend towards a nuclear family structure. The proportion of extended families fell from 37 per cent in 1984 to 29 per cent in 1992. The survey also revealed higher proportion of female-headed households (60.6 per cent) compared to males (1.4 per cent). These demographic trends and changes impact on the reproductive health of women.

Gender equity is not uniform: while male-female rates in literacy, employment and health status may be comparable, female wages and incomes are much lower. Relatively fewer women are found in positions of power either at the workplace or in parliament. The average life expectancy for women and men had improved from 73.5 years and 68.9 years in 1990 to 74 years and 69.3 years in 1995 respectively. Antenatal care coverage is also relatively high at 74 per cent in 1992; 73.8 per cent in the Peninsula, 74.6 per cent in Sabah and 73.9 per cent in Sarawak (Ministry of Health, 1990).

**Table 1: Gender Equity and Gender Empowerment Indicators, Malaysia 1995**

<table>
<thead>
<tr>
<th>Gender Equity Indicators</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (years)a</td>
<td>70</td>
<td>74</td>
</tr>
<tr>
<td>Adult literacy rate (%)</td>
<td>89.1</td>
<td>78.1</td>
</tr>
<tr>
<td>Primary school enrolment rateb (%)</td>
<td>51.3</td>
<td>48.7</td>
</tr>
<tr>
<td>Secondary school enrolment rate (%</td>
<td>49.1</td>
<td>50.9</td>
</tr>
<tr>
<td>Institutions of higher learning enrolment rate (%)</td>
<td>48.7</td>
<td>51.3</td>
</tr>
<tr>
<td>Share of earned income (%)</td>
<td>69.6</td>
<td>30.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender Empowerment Indicators</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional and technical workers (%)</td>
<td>56.4</td>
<td>43.6</td>
</tr>
<tr>
<td>Administrators and managers (%)</td>
<td>81.2</td>
<td>18.8</td>
</tr>
<tr>
<td>Seats held in Parliament (%)</td>
<td>88.7</td>
<td>10.3</td>
</tr>
</tbody>
</table>


a. 1998 data
b. government-assisted schools
**Table 2: Selected Health Indicators by Sex, Malaysia 1997**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude Birth Rate (per 1000)</td>
<td>26.1</td>
<td>25.1</td>
<td>25.6</td>
</tr>
<tr>
<td>Crude Death Rate (per 1000)</td>
<td>3.3</td>
<td>3.9</td>
<td>4.6</td>
</tr>
<tr>
<td>Stillbirth Mortality Rate (per 1000)</td>
<td>5.1</td>
<td>4.8</td>
<td>5.0</td>
</tr>
<tr>
<td>Neonatal Mortality Rate (per 1000)</td>
<td>6.7</td>
<td>5.1</td>
<td>5.9</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1000)</td>
<td>10.6</td>
<td>8.3</td>
<td>9.5</td>
</tr>
</tbody>
</table>


**Table 3: Trends in Economic and Health Indicators 1970s-1990s**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>1970s</th>
<th>Early ’80s</th>
<th>Late ’80s</th>
<th>Early ’90s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Domestic Product</td>
<td>7.5</td>
<td>5.8</td>
<td>6.7</td>
<td>8.9</td>
</tr>
<tr>
<td>Ave. Population Growth</td>
<td>2.4</td>
<td>2.2</td>
<td>2.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Crude Birth Rate</td>
<td>33.0</td>
<td>30.7</td>
<td>29.2</td>
<td>27.0</td>
</tr>
<tr>
<td>Crude Death Rate</td>
<td>6.9</td>
<td>5.2</td>
<td>4.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>4.9</td>
<td>3.8</td>
<td>3.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>38.5</td>
<td>17.5</td>
<td>14.0</td>
<td>11.6</td>
</tr>
<tr>
<td>Maternal Mortality Rate</td>
<td>1.2</td>
<td>0.4</td>
<td>0.3</td>
<td>0.2</td>
</tr>
</tbody>
</table>


**Kelantan**

The health indicators for Kelantan compare poorly with the national indices: a crude birth rate of 35.2 and infant mortality rate of 16.7 per 1000 live births. Although the national maternal mortality rate is relatively low, there are significant variations by state and ethnicity. Disaggregated data reveal more Malay women die at birth, not so much because they are a larger population but because of inadequate emergency measures, lack of physical access and modern transport. The state has the highest number of maternal deaths among Malay women. While the national modern contraceptive usage is 31.3 per cent among married couples, only 10 per cent of couples in Kelantan practise modern methods of contraception. It has been argued that cultural taboos, religious beliefs and use of indigenous methods of contraception (herbs and exercise) are some of the contributing factors (KFPA Annual Report, 1994 - 1995; Wazir, 1996; Suhaimi et al., 1996).

According to Dr Rashidah Shuib, Kelantanese women are active partners in economic development which includes the manufacturing, cottage industries and service sectors both in and outside the state. Research has shown that the religious beliefs and patriarchal values of the community shape women’s autonomy; often a Malay woman who makes decisions in the public sphere may not have control over her private life (Isa et al., 1999). Therefore, gender and social relations are factors to consider in any analysis of women’s reproductive health.

**Kelantan Family Planning Association (KFPA)**

The range of reproductive services provided by KFPA include contraceptive services, screening for breast and cervical cancers, treatment for gynaecological and menopausal problems, preliminary investigation of infertility and sub-fertility, referrals for specialist management, pregnancy testing and antenatal care. Other core activities include advocacy and educational programmes, family life education for youth, women’s development and resource development. Before 1990, KFPA covered about 40 clinics and "re-supply" points in five districts in the state. After the integration of family planning services into government clinics in 1994, KFPA now runs three clinics located in Kota Bharu, Tanah Merah and Machang. Following donations of a van and ultrasound machine from the Japanese Embassy in 1995, the mobile clinics began operating in Kuala Krai and Pasir Putih. While poor response led to the termination of services in Pasir Putih in 1997, services at Kuala Krai are now limited to a weekly clinic. Other services such as cervical smears are offered to women in the interior towns like Gua Musang and Pulai, about 200 kilometres from Kota Bharu. This research assesses KFPA’s services in terms of gender-sensitivity of care and explores women’s perceptions and experiences of reproductive health care.
The following is a summary of data collection methods used and the number of participants:

### Table 5: Data Collection Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Clinics</th>
<th>New Users</th>
<th>Continuing Users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situational Analysis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility checklists</td>
<td>4 clinics</td>
<td>105</td>
<td>494</td>
</tr>
<tr>
<td>Health providers’ interviews</td>
<td>13</td>
<td>86</td>
<td>414</td>
</tr>
<tr>
<td>Executive board interviews</td>
<td>3</td>
<td>14</td>
<td>389</td>
</tr>
<tr>
<td><strong>Women Users’ Perspectives</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td>9</td>
<td>131</td>
<td>761</td>
</tr>
<tr>
<td>Focus group discussions</td>
<td>7 (38 participants)</td>
<td>116</td>
<td>716</td>
</tr>
<tr>
<td><strong>Training and Capacity-building</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshops</td>
<td>2 (13 participants per workshop)</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

The core concepts used in the enquiry are access, gender-sensitisation and quality of care. Access to reproductive health services is defined in terms of physical distance to clinic (questions about perception of distance and ease of access), and cultural and social barriers affecting utilisation of services. Gender-sensitisation is interpreted as the extent to which women’s needs and rights are met and achieved. Quality of care was measured on a scale of six indicators: choice of methods, provider-user information exchange, provider competence, interpersonal relations, continuity of care and overall satisfaction.

### RESEARCH FRAMEWORK AND METHODOLOGY

The study adopted a women-centred, participatory action-oriented approach to initiate policy change and health seeking behaviour on the ground even as data gathering progressed. Women’s perceptions, experiences, needs and wants formed the empirical basis for the analysis. The health providers and senior management of the KFPA participated in the design, process and outcomes of the study. During the first field visit, the researcher discussed the various problems, challenges and issues faced by KFPA with the clinic manager and health providers and shared information on the research. In addition, despite selecting specific data collection methods, flexibility was exercised so that each step of the research was based on the outcomes of the previous step. A built-in action component focussed on training and capacity-building for KFPA staff. Data gathering methods included interviews, focus group discussions, document and situational analysis. Several field trips were conducted which lasted a month to six weeks from 1998 to 2000. With regards to ethics, verbal and written informed consent was explained and obtained from KFPA staff, women users and non-users who participated in the research.

### DATA COLLECTION

Situational analysis enabled assessment of KFPA services and considered access, gender-sensitivity and quality of care. Facility checklists gathered data on infrastructure of all clinics. Interviews were conducted with health providers and members of its executive board via standard questionnaires.

A facility checklist refers to the method of surveying the available facilities in the four KFPA clinics at Kota Bharu (headquarters), Tanah Merah, Machang...
and Kuala Krai (mobile). The checklist was filled by the clinic supervisor and, where possible, validated by the researcher via observation/inspection.

Health Providers’ Perspectives

The health providers’ questionnaire covered information on qualification and training, workplace changes and services offered. Information on management and clinical supervision were sought from the manager and clinic supervisor. Hour-long interviews were conducted with all 13 KFPA staff from the three clinics. Interviews with the Executive Board members focused on the range of services at KFPA and changes to family planning services that have a bearing on women’s access. Understanding of reproductive health issues, such as access and gender-sensitivity in quality of care and male responsibility, were explored. Only three of the five planned interviews with the Executive Board members were held.

Women’s Perspectives

Women’s perspectives and their assessment of KFPA were investigated through interviews and focus group discussions. Information covered in the questionnaire included socio-economic background, clinic services utilisation, access, needs, rights, quality of care and satisfaction. Given the qualitative approach used, the interviews were conducted using a convenience sampling rather than random, proportional sampling. Hence, nine women users who were at the clinics during the survey were interviewed in Kota Bharu, Tanah Merah and Machang. The interviews took place either before or after the user’s appointment at the respective clinics and lasted about 40 minutes to an hour.

The researcher met with staff of the three clinics to discuss preparations for conducting focus group discussions with both users and non-users. Three specific guides were formulated for each type of respondent, namely users, non-users, and users of traditional methods, with input and feedback from the clinic staff. The focus group discussions were conducted in a mixture of Bahasa Melayu and the local Kelantanese dialect. The management staff requested that one staff be present in the focus group discussion to observe the discussions among users and non-users. To ensure observers remained neutral, those posted at each focus group discussion session were not known to the participants. Rapporteurs familiar with the local dialect were recruited to assist the researcher who moderated the focus group discussions. Focus group discussions for women users were held at the clinics while non-users and those using traditional methods of contraception discussed the issues at the respondent’s home. A total of seven focus group discussions with 38 participants were conducted, with each lasting about two to three hours.

Table 6: Focus Group Discussions

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Type</th>
<th>No. of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kota Bharu</td>
<td>Users</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Non-Users</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Traditional Users</td>
<td>7</td>
</tr>
<tr>
<td>Tanah Merah</td>
<td>Users</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Non-Users</td>
<td>7</td>
</tr>
<tr>
<td>Machang</td>
<td>Users</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Non-Users</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>38</td>
</tr>
</tbody>
</table>

Training and Capacity-Building Workshops

In order to initiate change as an outcome of the research process, training workshops were incorporated into the fieldwork and conducted by the researcher, chair of the KFPA and resource persons. The two workshops addressed issues on gender and health, and attitudinal change among health providers. In addition to imparting skills for capacity-building, these workshops facilitated the understanding of prevalent perceptions of gender-sensitive healthcare and led to insights about group dynamics among KFPA staff. To some degree, it was possible to informally gauge the validity of the health providers’ questionnaire through the responses at the workshops. In the second workshop, the staff requested input on Islam and contraception as a result of the feedback on the major findings.
LIMITATIONS

Due to time constraints and logistic difficulties, volunteers including doctors, helpers and the Executive Board members at KFPA could not be included in the research. Nuances in processes such as fieldwork motivation, provider-user exchange and medical consultations would have surfaced had other data gathering methods including direct observation been employed. While some rich empirical data was collected, the study findings cannot be generalised to other similar reproductive health services in the country. Given the time and financial constraints, a larger sample size and wider geographical coverage was not feasible. Some phases of the action component were not synchronised with the study timeline since it was difficult to match the needs of all the providers at the three clinics. These had to be carried out after the completion of this study. The subsequent results then have been captured in the postscript report.

While there is concern that the study could be biased given the researcher’s ‘personal involvement’ as chairperson of the women’s development committee at the national level of the family planning associations (FFPAM), the researcher maintains that this might have increased the legitimacy of the study. This study could also have benefited from more exchanges and consultations with other project researchers from the different countries. However, the valuable email consultations with K. S. Tint and Lynne Hunt are acknowledged.

FINDINGS

Infrastructure

The KFPA runs three clinics in Kota Bharu, Tanah Merah and Machang where doctors and paramedics conduct checks regularly: twice a week in the Kota Bharu clinic and twice a month in the Tanah Merah and Machang clinics. Re-supply of contraceptives at the clinics is available daily. At the semi-mobile clinic in Kuala Krai, paramedic checks and re-supply are available weekly. Annual cervical smears are available for women in Pulai, a remote town several hundred kilometres from Kota Bharu.

All four clinics are functional with basic amenities including electricity and safe water. While there is a separate examination room in each of the three clinics, all clinics lack privacy for users and health providers. History taking and general counselling with users are done in the open space within the clinics. However, discretion is exercised during counselling on sexual problems and other private matters with users inside the examination room when it is vacant. Similarly, there are no separate areas for health providers to take breaks.

Health Providers

The 13-member KFPA team was made up of a clinic manager and clinic supervisor (considered senior management), eight fieldworkers, a secretarial clerk, an accounts clerk and a driver-cum-attendant. All were based at the Kota Bharu clinic except for three fieldworkers assigned to Tanah Merah and two to Machang.

<table>
<thead>
<tr>
<th>Data Analysis Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>The matrix below was used to assess and capture the meanings and implications of study findings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Accessibility</th>
<th>Gender-sensitivity</th>
<th>Quality of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Services Level/Providers’ Perspective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Infrastructure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(equipment &amp; facilities; staff &amp; training; supervision; keeping of records &amp; supplies; range of services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Care-giving process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(adequate knowledge; technical competence; rapport building)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Outreach work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Women’s Perspective</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
At the time of the study, the health providers had served KFPA between half a year to 17 years. The average duration of service tenure at KFPA was seven years, although half of the providers have been working there for more than ten years. Thus, the majority of the health providers could be considered long-serving staff.

The manager’s responsibilities include overall administration, reporting, planning and management of all programmes. As a qualified nurse, she initially carried out clinical services but currently covers the clinic supervisor’s duties when the latter goes on leave. The clinic supervisor who is a qualified nurse, manages the services at all clinics, performs examinations and screens users for referral to panel specialists.

The health providers were interviewed on their understanding of reproductive health and concepts such as access to gender-sensitive family planning services and quality of care. They were asked to assess KFPA's achievements and suggest ways to re-organise services. Other issues discussed included user information, rights and needs, supervision and monitoring, and in-service training.

### Access

**Women's perspectives**

The majority of users reported that the clinics were physically accessible because they are located within five to 11 kilometres from their homes. It is interesting to note that most women users did not regard domestic responsibilities, including housework and child care, to be barriers to access although they admitted that they had to complete all chores before visiting a clinic. Many users reported that husbands had no objections to their practice of contraception. However, one of them pointed out this might not be the case for some women: "Muslim women may not accept family planning and often, like their neighbours, do not know of such services in the town because their husbands would prefer them to stay at home."

Users from Tanah Merah and Machang, in particular, were more concerned about non-acceptance by close family members, neighbours, the village traditional midwife, and other villagers. This explained why they appreciated the ‘discreet location’ of the KFPA clinics, on the upper floor of downtown shops and away from the public eye. Some of them speculated that the main reason for the non-acceptance of modern contraception is the fear of side effects. They also believed that modern contraceptives would lead to “all sorts of diseases... to ugliness” that in turn could lead to rejection from husbands. Women users’ wariness of social non-acceptance of contraception echoes the concerns and frustrations of health providers over the same phenomenon.

Significantly, many non-users and those who used traditional methods did not agree that Islam was a barrier to accessing contraception. It was clear to them that Islam does not forbid family planning, as long as this does not include abortion, as reflected in the following comments:

- "Islam... it doesn’t forbid family planning."
- "It’s halal... she can plan (her pregnancy) before the meeting of the two seeds."
- "Since a child is also a gift from ourselves, we should plan the births."

Instead, they emphasised the importance of following Islamic principles for family planning and contraceptive practice. Almost all non-users had doubts about the material used to manufacture contraceptives as accurate information was unavailable on the packaging and from the service providers.

In contrast to the common belief that Islam is a barrier to women’s access to family planning, many of the non-users and those who used traditional methods identified fear of side effects of using modern contraceptives as the main barrier. Women from Kota Bharu cited side effects such as excessive discharge (‘wet’ and ‘watery’), weight gain, complications that could lead to high blood pressure and cervical cancer. Most of them were particularly concerned about the side effects of oral contraceptives. Surprisingly, non-users from the rural districts of Machang and Tanah Merah seemed more knowledgeable and less fearful of such side effects: “Side effects (like) headaches, putting on weight... it’s usual... not necessarily dangerous.” Some of them felt that side effects could have occurred because users might have been ill or had not followed the doctor’s advice.
Health providers’ perspectives

It is evident that the majority of health providers had a fair understanding of women’s access to reproductive services. Access was viewed as ensuring provision of comprehensive services under one roof for all and at appropriate times. The senior management felt KFPA had successfully facilitated women’s access to family planning services to women, in terms of service availability and affordability. One of the fieldworkers from the district clinics was particularly proud of the better access to KFPA clinics as they opened at times more suitable to women users and offered a wider choice of family planning methods.

Non-acceptance of modern contraception by Kelantanese society was identified as the biggest barrier to women’s access to family planning services. A fieldworker from the district clinic found schoolteachers, an educated group, to be most resistant to family planning. The findings also revealed that social non-acceptance of contraception affects continuity of care among women who practised family planning. Providers reported that because women feared husbands’ disapproval and neighbours’ gossip, home visits could not be conducted. Neither could they send reminders in the post as these would often end up in the houses of village headmen. Therefore they had to wait for users to turn up at the clinics for follow-up care.

It was acknowledged that there are groups of women who do not have access to KFPA services and programmes. These include rural women, unmarried women and adolescents who might either be in school or working in the factories.

Gender-sensitivity

Women’s perspectives

Needs

Majority of users tended to express needs related to family planning and reproductive cancer screening. Few reported needs pertaining to marital relations or parenting and so forth. During the focus group discussion sessions, many women users initially regarded these issues as part of the normal stresses of married life. Subsequently, with some probing, the group dynamics unravelled many other concerns and needs including the double burden of women who had to work because of husbands’ insufficient income, drug addiction among teenaged children, wife battering, polygamy and abandonment. Almost all of them, however, did not share these concerns with health providers because they thought the latter could not do much except advise or counsel.

Interestingly, non-users from Tanah Merah district raised specific needs pertaining to appropriate contraception for women above 40 years and contraception for men. They were keen to know if there were alternatives to the pill or injectibles as these methods either had side effects or were troublesome to use, and enquired about other male methods of contraception besides the condom. They were concerned that men tended not to use contraceptives. One of them agitatedly explained the lack of male responsibility in family planning: “Men don’t care... because they were never pregnant nor have given birth... they can’t understand women’s pain and suffering!”

Rights

Although most women users agreed with all aspects of reproductive rights, they felt strongly about joint rights between wife and husband over decisions on number and timing of childbirth. Women users in the focus groups, however, differed in their opinions on this particular right. The majority argued that as women were the ones responsible for child rearing and caring they should have the right to decide on childbearing and spacing. Some in the groups felt women should also discuss and consult with their husbands: “Although the right (to decide on childbearing and spacing) is with us, but should ask him too.”

Two of the women admitted to using contraceptives without the knowledge of their husbands. The focus group discussions also revealed variations in perceptions of the effect of Islam on reproductive rights. Some were of the view that while Islam does not prohibit family planning per se, the pill is not encouraged and the use of traditional herbs is more acceptable. Still others opined that the use of the pill is allowed in Islam since there is no fertilisation and implantation: “Islam asks that one be resourceful when it comes to having or spacing children.” Some felt that more than Islam, the negative attitudes of husbands and the surrounding community jeopardise women’s right to contraception.
Majority of the non-users and those who used traditional methods from Kota Bharu and Tanah Merah disagreed with people's perception that in their culture, only the husband decides on family planning matters and the wife obeys. They argued this based on three reasons: that husbands do not understand the hardships wives experience during childbirth and childcare nor do they realise that wives get tired and sick; that husbands are usually not knowledgeable about family planning methods; and that husbands do not take responsibility for contraception. According to one of them, “He doesn’t understand... asks me instead... this means that for this matter, I am the one who makes the decision more often.”

This is an interesting finding as it indicates that although these women might not be practising contraception, they were aware of rights to decision-making about family planning. In contrast, all non-users in the focus group discussion in Machang agreed that the husband should make the decisions as it is the norm in Islam and they believed this was for the good of the family. At this point, the oldest participant qualified that a husband should make decisions for the good of the wife as well as for the family, that is, he should consider his wife’s needs. Some of them felt that couples should cooperate and make joint decisions about family planning.

With regards to the right to informed choice about contraceptive methods, almost all users, non-users and users of traditional methods agreed they had the right to know the benefits and adverse effects: “We ought to be given information, only then we would know what methods of (family) planning... (we) must have the right.”

Similarly, most of the women agreed to the right of access to appropriate, acceptable and affordable health services. Users in Tanah Merah pointed out that the services at the KFPA clinic were reasonably priced and affordable. Although many of the women felt they should have the right to be listened to on health experiences and needs, almost all of them related they could not exercise this right in most government hospitals. Several of them related their negative childbirth experiences at the government hospitals where nurses had been impatient and harsh. While women in Kota Bharu did not feel this right contradicted Islamic principles, those in Machang and Tanah Merah felt they had to balance such rights with the need to seek husbands’ permission under Islam. That is, in some circumstances, Muslim women could not make certain reproductive decisions based on their rights as they needed husbands’ permission or consent.

**Health providers’ perspective**

Gender-sensitive family planning services were viewed as ‘access to eligible men and women’: eligible here refers by and large to married couples. It was pointed out that KFPA tended to focus on counselling issues pertaining to family planning methods and neglected other counselling needs to address sexual dysfunction, HIV/AIDS and family problems. Often they referred clients with such needs to other agencies. Senior management felt KFPA was providing gender-sensitive family planning services, although it was acknowledged that this did not necessarily lead to increase in new users or wider acceptance of family planning.

According to a district fieldworker, the unavailability of female doctors during clinic sessions has put KFPA on the ‘bad’ list. This lack of gender-sensitivity could have caused women to shy away from the clinics. All providers, however, were sensitive to women users’ preference for female doctors but the lack of female volunteers made it difficult for providers to satisfy this particular need.

Providers also readily acknowledged women’s expressed needs for care in areas beyond family planning services, such as RTIs, STDs, emotional problems, marital problems and wife battering. Malay women, in particular, had expressed problems about sexual relations. Significantly, some health providers were not comfortable handling such problems and usually referred women to specialists. Although providers may be aware of women’s other needs in addition to contraception, they were unable to address these needs. This could be due to their lack of appropriate training and the lack of gender analysis. Findings from the training session for health providers indicated that they had not been made aware of gender issues in health.

While health providers seemed aware of the rights of users to the choice of family planning methods”, they admitted that there were no formal mechanisms for users to be involved in the care giving process. The senior management
agreed that KFPA needed to empower users to assert their needs and rights. Nevertheless it was pointed out that users tended to say they had no problems or were satisfied. The lower expectations of KFPA could be because of the voluntary nature of the service. Such attitudes of users are related to ‘courtesy bias’ thought to be common in developing countries, where it would be impolite to demand for more or better quality services and expectations are generally low (Mensch, 1993, p. 249).

Quality of Care

Women’s perspectives

Many of the users interviewed rated the quality of KFPA services as medium to high for its choice of methods; provider-user information exchange; and provider competence, but significantly all of them rated interpersonal relations and continuity of care as high. The latter score is contrary to the low assessment made by the health providers themselves. The majority of users interviewed expressed their satisfaction with the services at the clinics.

Similarly, majority of women users in focus groups rated almost all the three clinics as high for all five indicators of quality care. In particular, they identified the excellent interpersonal relations, provider-user information exchange and continuity of care to be the best features of the KFPA clinics. Once again, many of them praised the caring and warm interpersonal relations that were viewed as unique to the KFPA and distinguished them from the other health facilities in the area. Contrary to the perception of some health providers, several of the women users in the focus groups appreciated the constant monitoring and examination once they began contraception. However, some women users still had lingering doubts about the pill and IUD due to the fear of side effects.

Most of the users were happy with the timing of the various services offered in the KFPA clinics, namely, in the afternoon and after office hours. Users also expressed satisfaction with the ‘discreet location’ of the clinics. This particular aspect of the clinics was considered more important than privacy during consultation. Although much of consultation except physical examination occurred in the ‘open space’ with other clients waiting in the same area, women were satisfied with the arrangement. It has been observed that although women can practice contraception, they prefer to ‘conform’ to the norm of social non-acceptance for modern contraception. It is relevant then to ask whether KFPA, by locating clinics away from the public eye, is being gender-sensitive to women’s needs while also perpetuating non-acceptance of modern contraception as practiced by Kelantanese society.

Interestingly, many non-users did not fault the competence and quality of care at KFPA for their non-use of modern contraceptives. However, users of traditional methods had no confidence in the health providers as they could not get information on the components of contraceptives, particularly if they were made in accordance with Islamic principles. Consequently, they were apprehensive about using contraceptives.

Health providers’ perspectives

Quality of care was interpreted as up-to-date services with availability of all methods, in accordance with the standards set out in the IPPF (International Planned Parenthood Federation) Quality Assurance Manual which was being implemented by the KFPA. When prompted to rate on the five indicators, namely, choice of methods, provider-user information exchange, provider competence, interpersonal relations and continuity of care, majority of the health providers rated interpersonal relations as high and continuity of care as medium to low. The clinic supervisor felt that the competence of the health providers in the district clinics was of moderate quality. Interestingly, the majority of district health providers also made the same assessment of their own competencies. Many of the providers tended to point to the lack of social acceptance of family planning as a major barrier in fulfilling continuity of care, although the clinic supervisor attributed it to the lack of resources to cover all the follow-up cases.

ACTION

Two workshops on capacity-building were held with health providers during the course of the research. The first, a one-day feedback and strategic planning workshop, was held to:
• provide feedback on the findings from the user interviews to KFPA staff/health providers; and
• discuss actions and strategies for problems and issues arising from the findings.

A total of 13 participants attended the workshops, including clinic management staff, field motivators, KFPA chairperson and the researcher. In response to the women users’ interviews, the three family planning clinics proposed the following Action Plans.
- Kota Bharu Clinic: Action Plan for Users of Traditional Methods
- Tanah Merah Clinic: Action Plan for Family Planning and Religion
- Machang Clinic: Action Plan for Diffusing Misconceptions of Family Planning

Towards the end of the research process, a two-day capacity-building workshop entitled “Gender-sensitive reproductive health: health providers for change” was organised for all providers. The objectives of the second workshop were to:
- reflect on personal experiences related to gender and analyse one’s beliefs and values;
- raise awareness about developing gender-sensitive attitudes and behaviours; and
- identify and apply gender-sensitive approaches and strategies in services and programmes.

A Muslim woman obstetrician and gynaecologist and a Muslim feminist activist from two NGOs in Kuala Lumpur provided specific inputs on Islamic and activists’ perceptions of women’s reproductive health (programme in the appendices). Providers were divided into three subgroups to discuss the following issues: Islam, gender and reproductive health; adolescents, sexuality and reproductive health; and gender, violence and reproductive health. Health providers were asked for input towards developing a public education booklet on Islam and contraception, a collaborative effort between KFPA and Sisters in Islam, an NGO in Kuala Lumpur advocating for Muslim women’s rights. These booklets have since been completed and printed in both English and Bahasa Melayu.

Field motivators were asked to evaluate and assess lessons learned from the research process and identify any changes in their work as a direct result of the research. Majority of them reported that the first workshop had revealed their weaknesses, particularly their lack of understanding of issues about family planning and Islam. However, the capacity-building workshop had helped them to better understand such issues. The field motivators reported more confidence when they carried out their motivation work with women as they could now deal better with some of the women’s doubts and fears of certain contraceptives from an Islamic perspective. Many of them also pointed out they had gained better understanding of gender concepts and gender relations/dynamics between men and women. One of them expressed how she could now practise gender concepts in her daily life as well: “... can apply gender concepts in (my) daily life... have the right to expression and decision making in the family.”

With regards to change/s in their work process, several of them reported increased awareness of women’s needs related to issues other than family planning and reproductive health. They said they had since begun asking women clients about violence against women if they suspected anything. Some reported they were now more confident about broaching questions on sexuality, women’s rights, gender-sensitivity and violence against women with their clients. However, one field motivator reported no changes in her work process: “... asked (women client) about problems related to violence... didn’t ask before but now (that’s) changed... (however) not yet a routine protocol.”

From the two capacity-building workshops and discussions with the researcher, KFPA decided on the following actions:
- Production of IEC materials, in the form of posters and leaflets related to men’s views on ‘male responsibility and involvement in reproductive health’. These new materials were considered to be more urgent given KFPA’s forthcoming expansion plans.
- Public seminar on gender issues, reproductive health and Syariah law to sensitise the public, particularly various agencies and NGOs with a related agenda on reproductive health in the state of Kelantan.
- Capacity-building workshop on inter-staff communication and management to ensure gender-sensitive sexual and reproductive health services.
In line with the above, a two-day residential workshop with KFPA staff was held to:

- evaluate KFPA services for women’s access to gender-sensitive sexual and reproductive health services;
- carry out a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of services; and
- identify strategies to address the results of the SWOT analysis.

Twelve staff participated and two resource persons, including the researcher, facilitated the workshop. An organisational as well as self-mapping exercise was carried out. SWOT analysis was conducted at three levels: organisational, work division and individual. During the mapping exercise, staff were able to see whether or not personal life and work goals matched with the organisational goals. There did not seem to be any significant mismatch between the two sets of goals. While several providers acknowledged family support, one staff admitted that despite her husband’s disapproval, she continued to work. Her persistence was evident from her attendance at this workshop despite her husband’s disapproval.

It became apparent from the outcomes at the workshop that the internal hierarchical structure and lack of resources (funding and trained staff) were more significant weaknesses than the lack of gender awareness/internalisation that was deemed to result in internal contradictions affecting the quality of sexual and reproductive health services. Subsequently, the staff worked together to identify strategies to address, in particular, their own weaknesses in four selected work divisions within KFPA: clinic services, field motivation, finance or/and management and programmes.

Almost all the staff felt this workshop gave them an opportunity to evaluate their work and personal lives. The SWOT analysis enabled a critical review of work divisions with participants and helped bring out differences in perceptions between providers and management, particularly the Executive Board. This outcome was new or different from previous training sessions, as reflected in these remarks:

“Regarding projects (programmes of KFPA) … should discuss first among staff, state manager and ex-co… this can be said to be something new.”

“(There should be) understanding between staff and ex-co… will bring good results/outcomes for KFPA.”

Some participants were of the view that only certain persons made decisions about programmes without necessarily considering the problems faced by implementers. Meanwhile, several participants said they felt closer to others and were more understanding of collegial problems and feelings. Although all staff participated with much enthusiasm, not everyone was completely at ease or open. This is understandable given that such an exercise was carried out for the first time. KFPA could continue with SWOT evaluations regularly to ensure better performance.

**RECOMMENDATIONS**

Despite limited resources and some overwhelming socio-political constraints, KFPA has endeavoured to implement recommendations made at international fora on access and gender-sensitivity in quality care for women’s reproductive health. It is hoped that KFPA will sustain and intensify efforts to train staff on gender issues. Both health providers and clients felt the KFPA clinics were relatively accessible in terms of discreet location, appropriate opening hours, wider choice of family planning methods and affordability. However, the overwhelming non-acceptance of modern contraception among the local communities was identified as a significant barrier hindering access for non-users and continuity of care for users. While it is true that Muslim women’s doubts about the manufacture of modern contraceptives has largely contributed to this social non-acceptance, it is crucial to acknowledge that public fear of adverse side effects of modern contraceptives (unfounded or not) is an important underlying cause for such negative feelings towards contraception. Therefore, health providers, policy makers and advocates of reproductive rights need to consider such factors as fear and non-acceptance of contraception in reproductive health services and programmes.
KFPA’s programmes should dispel fear of side effects of modern contraceptives and the commonly held perception that family planning is forbidden in Islam. Although Muslim women in Kelantan may be more open to family planning than previously assumed, there is a need to pay special attention to information, education and communication (IEC) materials used in the motivation and promotion of family planning to adequately address women’s doubts and fears. As part of the action component of the study, a ‘Question and Answer’ booklet on Islam and contraception has been compiled and distributed to the staff for their use during field motivation. As a practical or immediate strategy, KFPA field motivators could hold dialogues with women to dispel fears and doubts. The Board could also hold dialogues and train village leaders, Islamic teachers and traditional birth attendants who are trusted by the communities to help raise awareness.

KFPA could conduct an evaluation or pathway analysis to assess the effectiveness of its field motivation efforts. A long-term strategy could be to network with other related agencies, government organisations and NGOs, to collaborate in advocating for a more open discussion of sexual and reproductive rights and health. It is hoped that these short and long-term strategies could contribute to better understanding and increased confidence in modern contraceptives and remove prevalent negative attitudes. The study findings indicated that there is a sense of helplessness and low morale among health providers associated with social non-acceptance and low user rates. KFPA should address this issue in staff training.

Non-users who did not use contraceptives cited the fact they were already ‘old’ and hence could not bear children, although they were only in their thirties or forties and not yet menopausal. Clearly the contraceptive needs of such women who are still fertile but feel they do not want to have more children, need to be considered, particularly as confidential enquiries into maternal deaths revealed that maternal mortality was highest among mothers aged between 40 and 44 years old. This has implications for distinguishing between family planning methods for birth spacing and stopping childbearing. KFPA has to be sensitive to these specific needs of women aged 40 and above in its field motivation and reproductive health services.

Those who used traditional methods believed in the use of herbs and plant roots readily available from the local sundry shops, night markets, traditional birth attendants and traditional medicine shops within the neighbourhood at a low cost of RM5.00 (US$1.30) for a month’s supply. Policy makers and health service providers within KFPA need to effectively address the popular use of traditional methods in the promotion of modern contraception. At the same time, KFPA would need to advocate for policies and procedures that would ensure rural women, unmarried women and adolescents, both schooling and working, would no longer have difficulty gaining access to reproductive health services to assert their sexual and reproductive rights.

While women users could easily relate to their rights to informed choice, decision-making on childbearing and access to services, they found it difficult to conceptualise the right to be heard. Given the acceptance of gender-based discrimination and violence, such as domestic responsibilities, double burden, sexually-related problems and wife battering, as ‘normal stresses’ of married life, women are unable to understand how these ‘experienced but unexpressed needs’ can impact their sexual rights and reproductive health. In addition, analysis of cervical smear services at a remote community in Pulai several hundred kilometres away from Kota Bharu, revealed that while women were aware of the importance of smears for early detection of cervical cancer, they could not relate sexual behaviour to cervical cancer. Therefore access to smears does not necessarily lead to increased knowledge about sexual behaviour and its links with cervical cancers.

Health providers at KFPA, though aware of these ‘other needs’ of women, could not address them adequately because of limited trained personnel, heavy workload with inadequate staff and lack of awareness and training on gender analysis. For reproductive services and programmes to be gender-sensitive, there is a need for ongoing evaluation that measures the extent of recognition, promotion and respect shown for women’s human rights and assesses women’s autonomy in terms of empowerment through health (Matamala, 1998, p. 17). It is interesting that where KFPA may lack in infrastructure, technical and clinical competence, it compensates with high quality interpersonal relations and continuity of care. For the women, this quality of KFPA’s service distinguishes it from other health facilities within the community.
Given the action-oriented approach of the research, the study facilitated reflection, evaluation and discussion of issues and problems ranging from management, fieldwork motivation to women’s needs and rights. While the first workshop provided information from women for action plans to address some of the gaps in services, the second capacity-building workshop offered a forum to staff to view their lives and work in the context of gender and Islamic issues. It was noted that some changes had occurred both at the personal and work levels as a result of the research process. Staff were more confident in tackling women’s fears and doubts from an Islamic standpoint. Health providers now discussed issues such as violence against women with clients; they included women’s ‘other felt-but-unexpressed needs’ like sexuality and women’s rights in motivation and counselling work. While the SWOT analysis provided a forum for work review, the research process also revealed that, in addition to bringing about change in awareness and internalisation of gender concepts among the providers, change in the internal structure and control over resources in the KFPA was equally important. It is difficult to assess the long-term effects, including tangible changes resulting from intense but limited and ad hoc capacity-building sessions. Based on the feedback from health providers, there is clearly a need for sustained training programmes and regular evaluations.

**ACTIVITIES AND OUTCOMES**

- A strategic planning workshop to develop action plans for users of traditional methods, for family planning and religion and for diffusing misconceptions of family planning in three clinics.
- An orientation on gender concepts and gender dynamics/relations between men and women for staff to build confidence to allay fears of certain contraceptives from an Islamic perspective.
- A public education booklet on Islam and contraception was produced in collaboration with Sisters in Islam, following a capacity-building workshop with health providers who contributed their views and perceptions. This is the first such booklet on this topic in Malaysia widely distributed nationally to both service providers and clients.
- The first SWOT analysis of service workshop at organisation, work division and individual levels was held to see how personal life and work goals matched with the organisational goals, and to bring out the differences in perceptions between providers and the management, particularly the Executive Board.
- A half-day seminar on “Men against violence in families” to look at violence in families from the Islamic perspective since the violence against women issue was a concern identified by the staff of KFPA and allied NGOs in the state. This seminar was the first in the country targeting men specifically.
- As a follow-up to the half-day seminar, KFPA called a meeting with women NGOs in the state to discuss the directions to be taken by women NGOs in relation to the issues of violence. The result was a workshop on building the capacity of women NGOs in management skills to strengthen and professionalise their organisations, which was a first for women NGOs in Kelantan to receive such training.

**REFERENCES**


**NOTES**

1 Researcher and Chair of the Kelantan Family Planning Association (KFPA).
2 A highly visible feature of Kelantanese women's lives.
3 Supply of contraceptives only.
4 Needs included both expressed and those experienced but unexpressed. Rights included the right to informed choice; to decide on whether, how and when to have children; right to access appropriate and affordable health services; right to be listened to one's health experiences and needs; right to informed consent; and right to influence KFPA services.
5 This has been adapted from the checklist used in the South African research on “Transforming Reproductive Health”.
6 Except for IUD insertion, prescription, and heart and lung checks that are conducted by a doctor.
7 To decide on methods, doctor sessions, privacy and decision-making process in the running of the services and programmes.
8 Whether these contraceptives were made according to Islamic principles of halal or haram substances.
Women’s access to RTI services in Yunnan, China

Fang Jing, Xiong Qiongfen, Shi Zhenli, Guo Jimei, Zhang Jianping, Xiao Xia

INTRODUCTION

A number of studies conducted in developing countries reveal that reproductive tract infections (RTIs) are a common cause for women’s reproductive morbidity (WHO, 1998). Without early diagnosis and accurate treatment, complications from RTIs can result in infertility, ectopic pregnancies, cervical cancers and congenital infections that severely damage women’s health, fertility and productivity, and affect infant health and survival. Improving women’s access to quality RTI services is crucial for better reproductive health outcomes. This paper examines women’s access to RTI services in the affluent Guandu district of Yunnan province in China. Using qualitative methods, the study explores women’s access to RTI services in terms of geographic, information, economic, administrative and psychosocial factors. The study also examines the role of men vis-à-vis women’s access to RTI prevention and treatment, and suggests actions that can be taken to improve access given the prevalent socio-economic conditions.

While studies show a high rate of RTI among women in China (Kaufmann et al., 1997; Wu et al., 1999; Pan et al., 1995), both health providers and the public perceive RTIs as ‘women's diseases’. This perception may prevent women from seeking care and exclude men from participating in and taking responsibility for prevention, diagnosis and treatment of RTIs. Policy makers, medical practitioners and service providers tend to blame women for ‘unhygienic practices’ and consequently lesser resources are allocated to RTI services. Currently, the main focus of the maternal and child health (MCH) care services in Yunnan is to reduce the rates of maternal mortality (MMR) and infant mortality (IMR), and RTI among women. As women’s reproductive health is not only about childbirth but also includes sexual health and well-being, addressing women’s RTIs may provide a new entry point and approach to raise awareness on women’s reproductive health needs and lead to more gender-sensitive health programmes.
STUDY GOALS, OBJECTIVES AND RESEARCH QUESTIONS

In the Guandu district women live under comparatively better economic conditions than in other districts of Yunnan, with easy access to education, health services and transport. In addition, local governments have relatively more financial resources allocated to the health sector. While it can be assumed that women in resource-rich areas have better access to RTI services, this study attempts to answer the following questions:

• Do women in Guandu district have better access to RTI services than women in poorer areas?
• What are some of the access-related problems faced by women who already avail themselves to public health services?
• What constraints do these women encounter in seeking RTI services?
• What roles do men partners play in women’s access to RTI services?

The goal of this research is to disseminate the research findings on women’s access to RTI services in Guandu to policy makers, service providers and the public with a view to initiate policy change. The specific objectives are to:

• assess women’s access to RTI services in terms of the economic, informational, administrative, geographical and psychological factors that impact on women’s health;
• identify factors that obstruct women’s access to RTI services, particularly whether male partners play a part in hindering their access to these services; and
• identify actions that could be taken to improve women’s access to quality and gender-sensitive RTI services given the prevalent conditions and plans for change.

With health sector reforms underway county and township governments have the responsibility of financing local health institutions particularly in rural health services. However, decentralisation of finance and management has weakened the provision of health services in poor areas. Therefore poor women are less likely to access preventive care resulting in a widened gap between women’s needs and available services. The neglected state of RTI services is a typical example of such a case. While there have been several studies on RTI among women in rural Yunnan in the last decade, few of them have examined RTI services for women in urban or rich areas. This study is therefore unique and contributes to the body of knowledge on women’s access to health care. It will help policy makers develop more women-centred and gender-sensitive quality approaches to address RTIs.

CONTEXT: YUNNAN PROVINCE

While Yunnan province is less developed than other provinces and has 25 ethnic minority groups, Guandu district, with a population of 540,000 (280,000 urban residents, 260,000 rural residents and reportedly 200,000 migrants), has an established public health system and family planning (FP) service network. The district’s gross national product (GNP) was 76.1 billion RMB and the per capita income of local farmers was 3,978 RMB in 1981.

In the central town of Guandu, there is a comprehensive hospital, a traditional Chinese hospital, a maternal and child health care station and a district-level family planning service station. In each township, there is a health centre or hospital and 13 out of the 17 townships have a family planning service station. There is a health clinic and a family planning worker at each administrative village.

In 1996, the provincial Family Planning Commission selected the family planning service station of Guandu as the experimental site for providing comprehensive reproductive health services (quality of care programme). As a result, the family planning station expanded its services to cover maternal care, infertility management and contraceptive services. There are also other health institutions run by the army, private enterprises and individuals. The district government has allocated an extra 100,000 yuan annually as part of its health programme to reduce the MMR2 among poor women who utilise the hospital childbirth facilities. Several recent studies reveal that poor women reported high RTI symptoms yet their utilisation of RTI services was extremely low. For example, a study conducted in three poor townships of two counties in Yunnan found between 50 to 80 per cent of the women reported diverse
symptoms which implied the existence of RTIs. However, the percentage of these women seeking health care for the symptoms was only between 18 to 32 per cent (Fang et al.; 1997). Evidently, women in poor rural areas have limited access to RTI services and are constrained by lack of resources, poor knowledge and insufficient information on RTIs, inadequate services at community level, transportation problems and the impact of gender-biased traditional practices.

**CONCEPTUAL FRAMEWORK**

With this background, this study then aims to assess whether women in Guandu have better access to quality and gender-sensitive RTI services. Foreit (1998) defines access to contraception as the ability of people to obtain family planning from a service delivery system. Following Foreit, this study defines women’s access to quality RTI services as the ability of women to obtain RTI services from a service-delivery system. In this context, five dimensions of access were identified:

1. geographical (the number, type and location of services);
2. economical (costs of obtaining services);
3. administrative (norms and procedures that may facilitate or restrict a client’s ability to obtain services);
4. information (its availability to prospective users); and
5. psychosocial (social approval, stigma, individual attitudes that could facilitate or prevent potential clients from accessing services).

Quality RTI services comprise preventive and curative care. Moreover, the current concept of disease control covers prevention, progress of and complication from the disease. According to Elias (1997), the primary prevention of RTIs refers to infection prevention and includes health education, information delivery, counselling, voluntary and anonymous infection tests and promotion of barrier contraceptive methods such as condoms and spermicides. Secondary prevention covers early detection, diagnosis and management, particularly screening for asymptomatic infections as well as partner notification. Tertiary prevention is about prompt treatment of identified infections to prevent serious complications.

In order to determine women’s access to RTI services from a systematic and comprehensive perspective, the study adopts the conceptual framework expounded by Foreit (1998) and builds on the analytical categories of preventive and curative services elaborated by Elias (1997), to design the research methodology and collect data as well as to explain the findings of the research.

**RESEARCH METHODOLOGY**

The research adopts a qualitative and institution-based approach as few studies in China have examined access to RTI services by women who are reached by a service-delivery institution. Qualitative methods were employed to understand the women’s access to RTI services from three perspectives: women, providers and researchers. Methods used included in-depth interviews with women and providers, and observations of provider-client communications. These methods were chosen because they enabled a deeper understanding of women’s access to RTI services with the inclusion of women’s ‘voices’ in
terms of their perceptions and experiences that placed them at the centre of the analysis.

**DATA COLLECTION**

Initially the maternal and child health and the family planning stations at Guandu were selected as they provided RTI services to different groups of women and were representative of maternal and child health and family planning institutions in the rich counties of Yunnan province. As the research progressed, one clinic that provided sexually transmitted diseases (STD) services at a district hospital was also included in the study.

Research methods for data collection included observations, participant observations and in-depth interviews with women and men seeking care for RTIs, male partners of infected women and service providers. Guidelines were developed for the interviews with women and men clients. A semi-structured questionnaire was used to interview service providers. A semi-structured questionnaire was used to interview service providers. The data collection instruments were pre-tested and modified. Participant observation of the consultation process was also carried out after a checklist was developed to guide the observation. Documentation review was undertaken at the research sites through analysis of annual reports and client records.

Data was collected between February and June 2000 mainly at the maternal and child health and family planning stations. Fifty-five women clients, six service providers and three men clients were interviewed for the study. Thirty-one women and three service providers were interviewed at the maternal and child health station; 18 women, and two service providers were interviewed at the family planning station; three women, three men and one service provider were interviewed at the STD clinic.

Given that the interviews and observations were conducted within health institutions, steps were taken to prevent service providers from influencing the outcome, by altering their usual behaviour towards clients and/or preventing clients from confiding in the researchers. It was clarified to service providers that the purpose of the research was to understand women’s access to RTI services and not to assess providers’ performance. Care was taken to avoid interviewing clients in the presence of providers.

Some of the interviews lasted the whole morning as researchers listened to the women patiently and answered queries on RTIs and general health. As the women shared information and experiences with the researchers, other women (who were either waiting patients or accompanying friends) volunteered information as well. Informed consent was sought from all the women who were interviewed and all information divulged was kept confidential. Women were not asked to provide names or contact details. However, researchers shared their own names and contact details for purposes of clarification or assistance.

Two workshops were held among investigators to discuss and share their findings. The principal investigator consolidated the analysis between July and August 2000.

**LIMITATIONS**

Insights into women’s perceptions of access, coming from in-depth interviews, could help in the design of women-centred and gender-sensitive reproductive health programmes. However, the study is limited as women who do not access institution-based care were not part of the study and might well experience more constraints in accessing RTI services. Because the interviews were conducted within institutions, the environment and atmosphere may not have made women feel safe enough to express opinions openly. However, issues of feelings threatened by the atmosphere were minimised as the study emphasised women’s access to RTI services and explored factors that promote or impede their access rather than quality of service and client satisfaction.

Between a third and a quarter of those contacted by investigators could not be interviewed because of time constraints and unwillingness. Of these, many were migrant women. Hence, the findings from this study cannot be generalised to all women in the study areas. Despite these limitations, the study offers substantive insights into women’s access to RTI services in Guandu district.
FINDINGS

Access to Preventive Care

This section elaborates the findings on women’s access in terms of primary prevention of RTIs.

Information on RTIs

Women obtain information on RTI prevention only during the short consultation process. The contact between provider and client usually lasts five to seven minutes in one visit; in most cases, the provider only gives instructions on personal hygiene. For example, the provider would tell the client to wash her genitalia more frequently and sterilise her undergarments. Observations showed that providers rarely asked their clients to use condoms in order to prevent STDs. At both the MCH and FP stations, providers also rarely informed women that their partners needed to undergo examination and treatment as well. The treatment most often suggested included vaginal douching which has been identified by recent research to be harmful.

Women also receive information on RTIs from the mass media and advertisements for drugs and clinics. Advertisements persuade women to use douches and other personal hygiene products to prevent and cure RTIs. A popular advertisement exhorts women to buy a certain product by promising that ‘you can wash out your stubborn disease by using our washing liquid’. Women often buy drugs and personal hygiene washes over the counter and resort to self-treatment before going to a health facility.

While women with little education get information on RTIs only during medical care or from peers, public health journals provide such information to those who are literate and have access to such journals. Family Doctor and General Medicine are two popular journals frequently mentioned by women interviewees. However, the women maintained that the information in the journals did not fully meet their needs. A 30-year-old woman interviewed at the MCH station said, “I can’t find an answer for my condition from these journals.” Another 28-year-old woman opined, “Although there are many books and journals on medicine and health, the information specifically on women’s RTIs is very little, and we don’t know which book or journal is good.” Evidently, women have little access to accurate information on the prevention and management of RTIs because of the absence of formal and planned health education and information initiatives.

Condom promotion

Condom use is considered effective for the prevention of HIV/AIDS and STDs and therefore is integral to the prevention and management of RTIs. However, there is no condom promotion for RTI management at both the MCH and FP stations. Condoms provided to women are mainly for contraceptive purposes. Information on condom use for disease prevention only appears in HIV/AIDS prevention campaigns which mainly target men. Women therefore tend to ignore the fact that condoms offer protection as they do not consider themselves at risk of contracting HIV. Neither do they associate condoms with contraception as most of them use long-term contraceptives such as the IUD and sterilisation.

RTI screening services

A Ministry of Public Health policy directive enables rural women to undergo a gynaecological check every three years. This includes screening for some common RTIs such as trichomoniasis and candidiasis. Given the affluence of Guandu and the fact that the FP station has only been involved in a quality of care project since 1996, the local government allocated specific funds for such gynaecological checks at one to two-year intervals. The FP station coordinates mobile teams to provide services in villages with the medical fees borne by the district government and the village committee. Most women get free checks each year and some women receive money for their time. However, a few poor village committees cannot afford the check-up fee and the women in these villages have to pay partially for the service. Women in poor villages therefore have less economic access to gynaecological checks compared with women in richer villages. However, free checks are only for local women, so migrant women are excluded from the service.

The gynaecological check-up package has a small RTI component that only comprises a clinical check-up, including visual observation and abdominal bimanual examinations, and a simple laboratory test (specifically a wet mount).
to screen for trichomoniasis, candidiasis and bacterial vaginosis. Because these examinations only detect the infections with obvious symptoms and clinical signs such as vaginal sores, the causes for most infections, like STDs without symptoms and signs such as chlamydia and gonorrhoea, go undetected (except for trichomoniasis and candidiasis). It can be concluded that local women have better access to common RTI screening services to detect trichomoniasis, candidiasis and bacterial vaginosis and less access to STD screening services to detect asymptomatic chlamydia and gonorrhoea infections.

Gynaecological checks enable women to know where they can have their RTIs treated. At both MCH and FP stations, those diagnosed with RTIs by the mobile gynaecological check-up team were referred for further diagnosis and treatment. Although the gynaecological check-up service greatly increases the access of local women to common RTI screenings, it was found that some women still did not use the services for the following reasons:

- No knowledge of gynaecological examinations. Some women did not have details of when and where such checks could be done. These women were usually young, newly married and moved more frequently between places. Most likely they had not received information on available health services.
- Perceived poor quality of health care. A 35-year old woman interviewed at the FP station said, “I went to the check-up site, but found the condition to be very poor. The room for the gynaecological examination was crowded and there was no privacy. I felt uncomfortable being examined there and was afraid I would get an infection from the check-up. So I did not use the service.”
- Perceived non-necessity for medical tests. As some women did not feel pain or discomfort, they thought they were in good health and did not need medical attention. Older and less educated rural women were of the view that one did not need health care if one was healthy and ate, slept and worked well.

Access to Curative Care

The health and family planning service networks in Guandu are well established with a variety of private and public clinics and health institutions located at the village, township and district level. These clinics and institutions focus on providing services and seem to offer local women better access to curative services for RTIs. Because access to curative care includes geographic, economic, information, administrative and social access, this section of the analysis discusses those aspects of access which have a bearing on curative care.

Geographic access

While 70 per cent of the women attending MCH and FP stations lived within walking distance (five to twenty minutes walk) of the two institutions, the remaining 30 per cent have to rely on the bus and spend an average of one to two hours to get to the health centres. One informant took three hours to reach the MCH station by noon and then had to wait for two more hours for the centre to re-open. Most women who live far away from the MCH and FP stations therefore tend to first seek care at nearby clinics or hospitals. If problems persist they are referred to the MCH station. Clearly those living closer to the health institutions enjoyed better access. However, if the transportation system is good and if women have enough time and money, they can still access district level institutions.

Economic access

The findings revealed that examination and treatment fees charged for a single visit to the MCH station is between 30 to 80 RMB (about US$3.60 to US$9.70) or 10 per cent of the monthly income of the women or their husbands. Eighty per cent of those surveyed reported no difficulty in paying the fees. Only 20 per cent said that fee payments had an impact on their lives. These women were mainly retrenched workers or came from poor farm households. Two women from the same village who came to the MCH station for abortion concurred that, “Vulva itching and abnormal discharge are minor diseases. We can endure that and do not usually see a doctor when we experience those symptoms. Because we are poor we have to plan our expenditure and save money for more serious issues such as unwanted pregnancy, bleeding or pain.”

Very few migrant women were interviewed for the study as most of them accessed the MCH or FP station for family planning services rather than for RTI treatment. This suggests that migrant women, particular those with low incomes, have far less access to RTI curative services. In addition, findings
from the participant observation exercises conducted during consultations showed that migrant women could not afford to pay for treatments. Those who came to the MCH station for abortion or IUD insertion and found to have RTIs were required to have the infection treated before abortion or IUD insertion. However, these women found it difficult to comply as they lacked the money for RTI treatment and were also worried that their abortion or IUD insertion would get unduly delayed.

**Information access**

Women's access to information on RTIs was assessed through examining how and where women learned about RTI diagnosis and treatment and if adequate information was provided to them during health consultations. Findings revealed that there is no formal channel to inform women about RTI services except client referral. Women rely more on self-exploration or informal communication among peers. The following comments on information access are self-explanatory:

“I live nearby, so I know the MCH station.”

“One of my relatives is working here, so I came to this station.”

“Before I was married, I attended a school located at this street so I knew this station.”

“I brought my child here for immunisation so I knew they provide RTI services for women.”

“My friend told me about this MCH station.”

“One of my neighbours has the women’s disease so she came here and got cured. I have similar symptoms and she told me to come here.”

“I attended the gynaecological check-up in my village. The doctor told me to come here for further diagnosis.”

“I accompanied a friend here for her childbirth. I found out they provide gynaecological services for women.”

While women who were referred to the MCH station by village level or other health institutions could have gained information through a formal channel, there were cases where women did not seek prompt care because information was not available. Some even spent more time and money on accessing care in distant institutions. Most of these women were either older local women or migrants. The information and knowledge delivered by providers to clients during their visit to the MCH and FP stations is limited due to time constraints. The average time for a provider to see a client is five to seven minutes (including the time for gynaecological check-up). Even this time is divided into several phases of communication. Women said if they asked questions, providers generally responded, however, as providers are usually busy; women refrained from asking.
the next client. The client returns and the provider examines her to get a discharge sample (two to three minutes). The provider asks the client to take the sample to the laboratory room for testing, and continues to see other clients. The client brings back the test results. The provider reads the results, makes the diagnosis, prescribes the medicine and simply tells the client how to use the medicine (two to three minutes). The client leaves to buy the medicine. The consultation ends.

It is clear that clients get very little information on RTIs during one visit due to the limited communication between the provider and the client. During participant observations, it was found that there was little eye contact between providers and the women during their communication. Providers generally only told the women how to use the prescribed medicine and urged them to return if the symptoms persisted. They rarely explained to the women their disease and the causes. Providers did not tell clients who suffered from trichomoniasis that their partners needed treatment as well. No information was given on the side effects of the prescribed drug, metronidazole. In some cases, providers told the women their husbands needed to take medicine at the same time, but did not explain the reasons, thus causing confusion in the women. However, providers told most women with candidiasis that their husbands needed medication despite current research on RTIs revealing that partners of women with candidiasis do not necessarily need routine treatment.

I was told that if you sit on a seat occupied previously by a patient with syphilis you will contract syphilis. So I don’t dare sit on the seats in buses. (Woman, 29 years, middle school education)

I have been told by the older women in my village that vulva itch occurs when you occupy a seat previously occupied by a person with syphilis. I try not to sit in other people’s seats. However, I still got a vulva itch. I wash everyday, but I still feel itchy, I don’t know why. (Woman, 35 years, middle school education)

Administrative access
The district MCH station has 60 staff and five departments, including the obstetric and gynaecological outpatient department which is also responsible for providing diagnosis and treatment of RTIs, family planning services (IUD insertion and removal, abortion and menstrual regulation) besides pre and antenatal care. Only two providers and two rooms are allocated to this department. Whenever a woman comes in for abortion or other family planning services, one of the providers has to leave to attend to her while the second provider sees other clients. When there is only one provider on duty, clients seeking family planning services are given priority over clients seeking RTI services.

Of the two rooms, one room is for gynaecological examinations and RTI diagnosis while the other is reserved for antenatal care. The room for gynaecological tests is small and sparsely furnished with two tables and chairs for the providers, three stools for clients and one bed for examinations. A curtain separates the examination and consultation areas. Service providers do not have nurses assisting them. When the provider is seeing a client, others who are waiting for their turns tend to hover around and observe the consultation and communication. There is hardly any privacy so not much confidentiality can be maintained. Sometimes men who accompany their wives or girlfriends tend to enter the room as well, making the client more nervous and uncomfortable.

Women who regularly visit MCH and FP stations continue to have less access to information on RTI prevention and treatment. In addition, when providers give out information during consultations, women may not comprehend the given information because of the many medical terms. Migrant women tended to encounter language barriers. A migrant woman stated, “The doctor seldom explains my disease. Sometimes when she speaks I cannot understand or remember what she said.” Given the lack of access to accurate and appropriate information on RTIs, misconceptions and wrong perceptions prevail among women clients.
While the MCH station is supposed to provide treatment for RTIs, this is not the case as only limited services such as clinical examination and simple laboratory tests (wet mounts) are available. As mentioned earlier, asymptomatic infections like gonorrhoea and chlamydia go undetected. For example, a woman who asked the provider whether she had STD was given a negative answer based on observation of clinical signs alone. Referrals to a hospital for STD cases are made at the discretion of the providers. The reasons given by providers for not diagnosing and treating STDs include the following:

“The condition here is poor, the room is narrow and we don’t have good sterilisation equipment.” (Provider A, 32 years old, MCH station)
“We are afraid to provide STD services (check-up and treatment) as there is a chance that other women, particularly pregnant women may get infected because of limited space and poor sterilisation.” (Provider B, 41 years old, MCH station)

The research findings indicate that RTI services are not a priority at the MCH station, with poor and inadequate quality of services for STDs. Women attending the MCH station in fact have no access to STD services. A 23-year old unmarried woman had two sexual partners, one of them was suspected of having multiple partners. When the woman experienced vulva itching and excess vaginal discharge, she visited the MCH station several times and also went to a traditional Chinese hospital. While both institutions prescribed medicines, she was not asked about her or her partners’ sexual behaviour nor did she receive checks for STDs except for wet mount. Her condition was treated as a general gynaecological disease. The woman continued to seek care at different health institutions.

Observations during clinical procedures revealed that providers rely on personal experience and knowledge because there is no standard clinical protocol to follow. Poor and inadequate service often results in ineffective diagnosis and treatment. For example, a woman with abnormal vaginal discharge had been visiting different hospitals for three years without any improvement. Another woman was diagnosed with trichomoniasis and had spent nearly 1,000 yuan (US$120) for treatments at various institutions without any success. During the interview, it was found that because she was breastfeeding she was afraid to take oral medicines and had only used vaginal medicine inconsistently. She was not given clear instructions on medication and her husband was also not advised on treatment.

While the infrastructure at the FP station is better than the MCH station, the quality of RTI services provided is similar. The fact that there are two big and bright rooms for gynaecological and obstetric service and a room each for consultation and check-up has not made a difference to the type of services offered for RTIs. The FP station can only diagnose and treat common RTIs such as trichomoniasis and candidiasis even though one provider has received training in STD treatment. Other STD services are not available within the station.

Inadequate administrative access for women has affected the quality of care. Some women expressed dissatisfaction with the service particularly the absence of one-on-one service and the lack of privacy and confidentiality. As a result, one woman turned to another hospital where privacy was assured. Evidently, both the MCH and FP stations do not provide STD services which are increasingly needed by women in general.

**Psychosocial access**

Women who frequently visit the MCH or FP station are used to the environment and providers and tend to be less nervous when presenting their symptoms. In contrast, first timers and poor rural women are more constrained by psychosocial barriers including fear of being labelled ‘bad women’ by providers. One woman washed herself repeatedly before seeing the doctor for fear of being labelled dirty and condemned. About half the women interviewed said they were nervous during the examination and afraid of being diagnosed with RTIs. These women did not seek immediate care when they experienced the symptoms but instead, bought over the counter medicine and washing liquid for self-treatment. Only if and when the symptoms persisted or got worse did they visit the health institutions.

Social mores, self-perceptions of good health and work burden are significant factors that influence women’s access to RTI treatment. Women often perceive RTIs as an embarrassment and shy away from seeking medical help. However, a provider’s concern and caring attitude can help women
overcome these barriers. For example, a woman with RTI who initially kept away from getting help was urged by her family and friends to visit a clinic where she met a doctor whose concerned manner and professionalism proved helpful and encouraging. In some cases, women believe their health condition is good and does not warrant gynaecological checks. Women who have to work to support their families are constrained by time; this is particularly so for rural women who become effective heads of households when husbands migrate.

The Role of Men

The majority of women interviewed had the support of their husbands, particularly those who were better off financially and had good relations with their spouses. While one husband persuaded his wife to attend a bigger hospital because he assumed that a bigger hospital would provide better service, some husbands accompanied their wives to see the doctor. Some of the women mentioned that their husbands were concerned about their condition and offered encouragement and financial support. While there were husbands who were indifferent to their wives' condition, they did not stop the women from accessing RTI services. By and large, it seemed that husbands played a positive role in facilitating women's access to RTI services.

In the case of unmarried women, usually their partners were unaware of their condition. As very few unmarried women were interviewed, there was not much information on the reasons for the non-involvement of partners. Questions can be raised here about societal disapproval of premarital and extramarital sex that may have a bearing on the non-involvement of partners in this case. In addition, as unmarried women are not expected to be sexually active in Chinese culture, they may well have wanted to be discreet about their situation.

While the study shows that husbands do not necessarily play a negative role in women's access to RTI services and in some cases, even encourage women to seek help, men still do not take responsibility for the prevention and treatment of RTIs. Three men who attended the STD clinic said they would not tell their wives or girlfriends about their own condition if they had the RTI treatment because it would damage the relationship between them. However, if their wives or girlfriends had abnormal symptoms, they would encourage them to seek care.

Almost all of the women said their husbands did not want to wash their penises before sex and use condoms. Some women became pregnant and underwent abortions several times because their husbands refused to use condoms (these women had contra-indications for IUD or experienced IUD failure). One woman experienced itching and discomfort each time she had sex with her husband. When she asked her husband to use condoms, he not only refused but also suspected her of having extramarital sex.

When providers asked some women with RTIs to ensure their husbands take medicine, a few of the husbands refused to comply. One husband said to his wife, "Why should I take medicine for you, it's your problem?" In some cases, women were not very clear why their husbands needed medication. This situation clearly resulted from a lack of information during consultation and treatment. When providers told the women to ask their partners to take medicine, they did not explain the reason for this. Many women strongly urged the providers to directly educate their husbands on the need to take responsibility in the treatment of RTIs. The women lamented that husbands trusted doctors more than they trusted their wives. One woman even suggested that providers invent a medicine for men to put on their penises to avoid transmitting diseases.

The findings suggest that even if all women had good access to RTI services, they still could not reduce the morbidity of RTIs if their partners did not take responsibility in RTI prevention and treatment. Therefore, the issue of men's participation is very important.

CONCLUSIONS

In the light of the above analysis, the following conclusions can be drawn:

- Women lack accurate information on RTIs mainly because of the absence of health education and limited communication with the
providers. Medical procedures and language barriers further mystify the health care system and make access to information problematic.

- STD services provided at both the MCH and FP stations are inadequate. Data from one clinic showed that women only accounted for 10 per cent of all clients, suggesting that most women seek care at the gynaecological and obstetric department where STD services are not available. Therefore, women have less access to STD services, and the diagnosis and treatment may get subsumed under gynaecological problems and received inappropriate management and care.

- Women do not get quality treatment for RTIs despite a well-established family planning network and a range of health institutions with provision of RTI services. This is because of the lack of adequate infrastructure, trained personnel, and the absence of appropriate clinical protocols and monitoring and regulation mechanism.

- Absence of counselling services at both the MCH and FP stations make it difficult for women diagnosed with RTIs to receive adequate emotional and psychological support particularly on how to communicate issues of prevention, protection and treatment with their husbands or partners.

- As women cannot reduce the morbidity of RTIs on their own, the inclusion and participation of male partners in women’s access to quality RTI services becomes imperative.

- Poor and migrant women face economic constraints, live far away from health institutions, face more social barriers in communicating with providers and experience language barriers that impede their access to information. All of these factors result in them having the least access to RTI services.

- There is a need to integrate RTI services with family planning services as women tend to access gynaecological care more than STD and RTI services. If the MCH and FP stations only limit their services to diagnosis and referrals for RTIs, women would not be able to get access to integrated reproductive health care.

Compared with poor rural areas in Yunnan, women in Guandu district can be said to have better access to both preventive and curative RTI services in terms of geography and economy. For most of the women interviewed, finances, distance and transportation are not barriers impeding access to services. However, these women still face problems related to the quality of care, gender-based assumptions, unequal gender relations and traditional practices that affect access to RTI services. Despite being able to reach health care institutions, women in Guandu still share the gender-based discrimination and marginalisation experienced by poor women in rural Yunnan.

**RECOMMENDATIONS**

Based on the findings and conclusions, it can be said that women’s access to RTI services in rich areas like Guandu still needs to be largely improved. Considerable efforts have to be made to increase women’s access to quality care and gender-sensitive approaches in programmes. The following specific recommendations are made with a view to influence policy changes.

**Service Reorientation and Restructuring to an Integrated Reproductive Health Approach**

Currently, services focussing on maternal and child health care and family planning are the two major systems for providing reproductive health services in China. The dermatology and venerealogy departments of hospitals provide STD services. This vertical and independent service system results in an inadequate provision of RTI services to women. The reproductive health approach emphasises a women-centred and gender-sensitive approach and is oriented to meet clients’ needs. Therefore, health policy makers and programme managers need to shift the narrow maternal health care plus family planning delivery mode to a broader reproductive health approach by restructuring service organisation and delivery to increase women’s access...
to RTI services. Service stations should draw up a clinical protocol to avoid the situation of providers using just their personal judgement in handling the cases.

The reproductive health approach also requires expansion of RTI services to cover measures that promote men’s involvement in prevention and control of RTIs among women. In addition, a more comprehensive service for women's reproductive health care needs to be implemented. For example, RTI services can be integrated with family planning services. Providers could recommend other contraceptives for women who are unable to use IUDs.

In order to improve women’s access to STD services, both the MCH and FP stations could provide STD services for women with RTI symptoms or abnormal conditions. However, further discussion with providers and managers is required to explore a feasible and acceptable approach to integrate maternal and child health and family planning services with STD services.

**Dissemination of Information**

Widespread dissemination of information and knowledge of RTIs is immediately needed to increase women’s access to services. Appropriate and gender-sensitive information presented in an accessible manner will inform women on their rights to services, where to seek care, the consequences of not seeking prompt care, and also help them overcome fear and embarrassment. However, given the drive to privatise health services, care should be taken to increase information delivery and ensure accuracy of information. Health education should be emphasised by the government and supported by adequate resources.

Meanwhile, health institutions should ensure that basic and important information is provided to clients during even the briefest consultation. Attention to individual women's needs, one-on-one counselling and communication are essential in addition to making general booklets, pamphlets and books available during consultations. Men’s participation needs to be encouraged. The doctor (regarded as an authority figure) could issue a note to husbands requiring their support and participation in the prevention and treatment of their wives’ RTIs.

**Upgrade Providers’ Knowledge and Skills to Improve Quality of Services**

Providers’ knowledge and skills could be outdated considering the extent of new findings of research on RTIs, leading to poor quality of services. Training providers to upgrade their knowledge and skills could improve the quality of services. Training should not only address biomedical knowledge and skills but also interpersonal skills, including methods of treating RTI clients in a non-judgmental manner. Methods to improve the quality of services should take into consideration changes in the physical and psychological environments of health institutions. The quality of services could further be improved by strengthening monitoring and supervision, regulating providers' behaviour, and developing and implementing appropriate clinical protocol.

**Providing Diverse Services to Meet Different Needs**

Given the social reform underway in China, particularly the increased privatisation of health care and implementation of service fees for health services, the poor, migrant, and jobless women become even more disadvantaged where access to RTI services is concerned. These women are already disadvantaged because of language and information barriers and psychosocial factors that impede their access to services. More affordable and accessible services need to be provided for this group of women. Health institutions need to consider diverse RTI services, including low-cost RTI services (low-cost but effective laboratory tests and medicines) to meet their needs in a practical manner.

All recommendations mentioned above need to be communicated to policy makers, service provision departments and providers. Considerable advocacy at policy and programme levels is needed to implement these recommendations.
ACTIVITIES AND OUTCOMES

Workshops with policy makers, service providers and women clients were held to discuss the findings. The workshops had the following outcomes:

• It was the first time for the researchers to share research findings with both policy makers, service providers and the women clients at different settings in a participatory manner where each stakeholder had equal opportunity to share, discuss and dispute. For the researchers, they felt honoured that they became the channel for women clients to express their views, and to share the findings with the policy makers and service providers.

• The workshop with the policy makers and service providers enabled two different sectors - maternal and child health and family planning - to come together to discuss RTI issues as there were not many opportunities for them to do so due to their work.

• The meeting with women clients of a family planning service station served to fill the gaps in information that women face with regards to RTIs from the numerous questions raised and interest shown by the women at the meeting.

• The participants from the family planning system expressed their interest to have more guidance and technical support from the research team and Yunnan Reproductive Health Association in the future. Two future projects were developed in collaboration with the research team and two family planning service sectors to improve RTI services after the research findings’ workshop.

• Participants from the family planning sector were found to be more open to new knowledge on transmission of RTIs compared to participants from the maternal and child health sector, who resisted new knowledge and updated information on RTIs that challenged their beliefs and practices gained in their routine work. This revelation could be used for future interventions.

• Commitment to reprint more IEC materials on RTIs developed by the research team from one of the family planning service stations if the IEC materials run out.

• The dual roles that the researchers had to play in this project - one as a researcher and the other as a woman health activist and advocate - made them realise the different sets of skills and competencies that each role requires.

REFERENCES


In many districts of Yunnan province, the per capita income of farmers is less than 1000 RMB. RMB or ren min bi is the currency of China that utilises a system of three units, namely yuan, jiao and fen.

The hospital delivery rate in this district is 98% and the MMR is between 20 to 40 per 100,000 live births and IMR ranges between 18 to 25 per thousand live births. The MMR in Yunnan was 101.39 per 10,000 live births in 1999 while the MMR for the whole country in the same year was 60 per 10,000 live births.
A women-centred analysis of birthing care in a rural health centre in Bangladesh

Kaosar Afsana and Sabina Faiz Rashid

INTRODUCTION

This study examines maternity care at Bangladesh Rural Advancement Committee (BRAC) in rural Bangladesh and assesses the extent to which health care provision meets women's needs and expectations during childbirth. BRAC is a development non-government organisation (NGO) involved in projects addressing education, health care, micro-credit, gender relations and other socio-economic concerns of the rural poor. BRAC formally launched 21 BRAC’s Health Centres (BHCs) in 1996 and two of them have operated as maternity waiting homes since 1992. Using a qualitative approach, the research examines the perceptions and experiences of women who access BHC maternity services and explores the roles of health care providers including medical professionals, traditional birth attendants (TBAs) and others, particularly male and female kin, who influence women’s childbirth experiences.

Given the women-focused approach and the fact that micro-realities of women’s lives have also been captured, the study offers a clearer understanding of the socio-cultural issues affecting women’s access to birthing care. These include the way in which the service quality and the power dynamics between women and health providers affect women’s birthing experiences. In addition, insights into the social relations between expectant women and male and female kin provide relevant information on decisions made by the family during childbirth. The findings from the study can inform the design and modification of service delivery approaches to enhance women’s access to maternity care.

STUDY GOALS AND RESEARCH QUESTIONS

Both government and non-government sectors are working to improve maternal health through essential obstetric care (HPSP Part I, 1998; Bangladesh Fourth
Population and Health Project, 1999). However, more than 90 per cent of births in rural Bangladesh take place at home with hospital care used rarely and only in life-threatening situations (Bangladesh Bureau of Statistics, 1997). This study therefore becomes particularly important to policy makers and health planners. While research shows that the use of health facilities during childbirth reduces incidence of maternal mortality (Maine, 1996), people still hesitate to seek birthing care from the hospital unless an emergency obstetric situation occurs (World Bank Report, 1999). Barriers to hospital care include socio-economic causes, issues of access and more importantly, the poor service available at health facilities (Goodburn, 1995; Junker et al., 1996; Juncker & Khanum, 1997; Gazi, 1998). The low utilisation rate of BHC services raises three questions:

- What are women’s understandings of childbirth and its related practices?
- What are the gaps existing in the quality of care at the health facilities?
- How do power dynamics at home and hospitals hinder women’s access to BHCs?

This research aims to explore women’s beliefs and practices about childbirth and their perceptions and experiences of health care to assess women’s role in childbirth decisions. By also assessing health providers’ views on childbirth services, the study identifies barriers that prevent women’s needs and expectations from being met and recommends gender-sensitive strategies to improve childbirth facilities for rural women.

CONTEXT: BRAC’S HEALTH CENTRES

The BHCs are established in each thana and provide basic obstetric care including ante- and postnatal services, outpatient and laboratory facilities. The government district hospital serves as the referral centre. Each BHC is staffed with a medical officer (MO), two or three paramedics, a family welfare visitor (FWV), a laboratory technician and a female attendant. Female paraprofessionals are trained nurses or midwives who get further training in midwifery at BRAC. The BHC promotes ante- and postnatal treatment at community levels with field paraprofessionals and health volunteers providing advice and care. Even with the unsatisfactory results of the TBA training programme, BRAC field staff maintains contact with TBAs, with some receiving remuneration for participating in different BRAC activities. In fact, women are urged to seek care from trained TBAs. Despite BRAC’s effective communications with the community, the utilisation of the BHC remains low.

While studies point to poor communications, economic constraints and the lack of comprehensive obstetric services for the low access to BHC services (Afsana & Mahmud, 1998; Shahaduzzaman, 1998), there is no record of women’s needs and expectations during childbirth that would help identify barriers preventing the utilisation of BHC maternity services. Cultural norms and practices, particularly notions of pollution and belief in the supernatural, shape rural women’s understanding of illness which in turn affect health-seeking behaviour (Blanchet, 1984; Rozario, 1993). Gender roles and social relations also determine choice of health care during childbirth. In rural Bangladesh, husbands and mothers-in-law tend to be the major decision-makers, particularly when maternity care is sought outside the home (Gazi, 1998; Norris-Stark, 1993). Beyond the household, the biomedical establishment with its power of medical hegemony also wields considerable influence (Lazarus, 1997). The ‘authoritative knowledge’ of the medical profession dominates and precludes women’s ‘knowledge’ of their bodies during childbirth (Lazarus, 1997; Jordan, 1997). Consequently, unequal power relations at the household level get reinforced in medical settings and women’s sense of self-entity and identity becomes obliterated. Although studies have documented the hierarchical power relations between medical professionals and poor rural women (Rashid, 1997), women’s understandings of childbirth and the effect of gender roles and power dynamics on their use of obstetric care are not sufficiently explored in Bangladesh. This study hopes to address these gaps in previous research.

RESEARCH METHODOLOGY

The study is premised on principles of participatory action-oriented research and uses a qualitative approach in data collection and analysis for the assessment of gender-sensitivity in BHC’s maternity services. During fieldwork, information on gender-sensitisation in health care was shared with health providers and
rural women were made aware of their rights to obstetric care. The action component of the research has ensured that the training division of BRAC will initiate training on gender-sensitivity in health care for health providers.

Women aged between 20 and 40 years who had experienced childbirth were the main focus of the study. Two categories of women were selected: those who experienced both BHC and home birthing and those who only delivered at home. By reviewing programme registers of women who had delivered at the BHC not more than two years ago, 15 articulate women were chosen from different villages, out of which nine had delivered at the BHC and six were referred to the district hospital. Five women who had given birth only at home were identified from selected villages in consultation with other respondents. The number of respondents was limited to five because the information from them was extensive enough. In addition, two trained and three untrained TBAs were identified for in-depth interviews with the assistance of BRAC field professionals and women respondents. For focus group discussions, 21 women between 20 to 40 years were selected with the assistance of the community health volunteers. Four physicians and seven female paraprofessionals of the adjacent BHCs were also invited to participate in the study.

DATA COLLECTION

Fieldwork was conducted from November 1998 to January 1999 at a BHC located in a district town 300 kilometres north of Dhaka. The institution started as a maternity waiting home in 1992 and became a BHC in 1996. It recorded a higher utilisation rate of maternity care due to its close proximity to district hospitals and villages. Although the fieldwork was done during a specific duration, varied experiences of women were included during data collection.

In-depth Interviews

In-depth interviews was the principal method used to gather women’s perceptions and experiences of birthing. Women's 'voices' formed the central part of the study. The community health volunteers introduced the researchers and initiated informal discussions to establish rapport with the research community. The study aims were shared and verbal consent sought before the women were informally interviewed. The interviews lasted two to three hours depending on the responses and the extent of information collected. One researcher asked questions and the other took notes based on guidelines developed to lead the discussion in a participatory manner. If any interview remained incomplete because the women were busy with chores, they were interviewed later. However, two women were reluctant to participate and dropped out of the study. TBAs were interviewed on their experiences in birthing practices. If gaps remained in the interviews, they were addressed the next day or later on a follow-up visit.

Focus Group Discussions

Three sets of focus group discussions (FGDs) were carried out with a group of six to eight women. The purpose was to examine rural women's beliefs, understandings and practices about childbirth, and attitudes towards home and hospital birthing. The focus group discussions were carried out at conveniently secluded sites in a study participant’s home, with one moderator and two assistants guiding the discussions. Each session was tape-recorded and lasted more than one to one-and-a-half hours.

Informal Discussions

Informal discussions with the health providers took place at the BHC: one with physicians and the other with female paramedics. Various issues were addressed, particularly the capacity of the centre to meet rural women's needs, client satisfaction with quality of care and the barriers to provision of quality care. Participants’ observations were used to assess client-provider interaction, staff competence and attitudes towards clients and their families, and the availability and affordability of services.

Observations

Observations were also used as a research method. The researchers observed four women who gave birth at the BHC from the day of admission to the day of discharge. During fieldwork, all activities at the BHC were recorded. Initially,
the health providers were uncomfortable in the presence of researchers, making it difficult for the latter to observe and record ‘real’ situations. Eventually, a more normal situation emerged after the researchers became more familiarised with the institution and tried not to interfere with routine work. Acceptability was also enabled because one of the researchers had known the BHC staff for more than six years.

DATA ANALYSIS

Data processing, including transcription and analysis, was carried out at the same time as data collection. All transcripts were carefully checked for accuracy and consistency. Major themes were identified to address the research questions. The ‘voices’ of the informants were included in the analysis to prevent their words from being lost or misrepresented. To validate the data, triangulation of methods and sources of information was applied.

ETHICAL CONSIDERATIONS

The research proposal was presented to BRAC programme implementers for fieldwork approval. BHC health providers and study participants were verbally informed of the research objectives, its usefulness, methods and benefits, as well as the purpose of using photographs. The participants’ consent was obtained verbally as the use of a consent form is not seen as culturally appropriate in rural Bangladesh. Interviews were conducted only at select venues to ensure confidentiality and privacy. Tapes and transcripts were anonymously coded. The position of the researchers vis-à-vis their association with BRAC was clarified. The researchers were respectful of the participants and their views, and remained non-judgemental.

LIMITATIONS

The findings cannot be generalised as the study was conducted at a specific site with a limited sample. Issues of selection bias are likely as the research relied on the assistance of BRAC community health workers. Steps were taken to minimise this bias by following a selection criteria. While observer bias could have occurred because of the presence of researchers during childbirth, this was minimised after health providers and clients became familiar with researchers. The use of multiple methods and sources of information reduced some limitations of the study, while the checking of internal data consistency helped minimise existing biases.

FINDINGS

Beliefs and Practices of Childbirth

Cultural constructs of childbirth are central to rural women’s perceptions and experiences: birth models described by women are similar to indigenous models of sickness and health (Lazarus, 1997) that shape their health-seeking behaviours. Health care sought during childbirth reflected rural women’s understandings of childbirth and their reformulation of the cultural constructs of ‘normal’ versus ‘complicated’ birthing.

Normal versus complicated birth

Notions of ‘normal’ and ‘complicated’ childbirth are constructed in the context of cultural and social practices. Women’s choice of birthing care depends on the way birth is constructed. For rural women, the act of childbirth is a normal, natural phenomenon. Normal childbirth process is understood to be ‘kono oshubidha hoi nai’ (having no difficulties) and takes place at home, either unassisted or assisted by TBAs. On the other hand, bekaidai or ‘complicated’ childbirth means ‘something serious has happened’ that cannot be managed by TBAs and needs hospital care. For normal childbirth, families usually prefer experienced TBAs - known as dhaitanis - from within the community. In some cases, a village doctor is called when the TBA is not able to assist with the labour. The village doctor always responds by treating the women with saline and injections. Women taken to the BHC because of failure of home treatment are labelled deviant. On the other hand, women who choose hospital birthing are not perceived as deviant. Health-seeking behaviour is gradually changing with a larger number of younger and educated women seeking care from
health professionals as perceptions and understanding of childbirth have also changed.

**Beliefs in supernatural causes**

Evil spirits, spells, bad wind and witchcraft are perceived to cause birthing problems; pregnant women are considered particularly vulnerable and expected to follow particular norms to experience normal and safe home birthing. Women often blame evil spirits for casting spells if a pregnancy does not go smoothly. Beliefs about evil spells and spirits are reinforced when biomedical professionals fail to treat complications. A respondent’s narrative painted a graphic picture of such beliefs:

> When my second child was born, a man did ‘asli kata’ (black magic) on me. I felt very ill in my late months. I went to the missionary clinic to have my baby but they sent me home, as I was not ready to have the baby - the time had not come yet. A few days later, I felt that ‘bachha petey koliyah phetay jabbey’ (with this baby in my stomach my heart would burst). I had injections and saline but my pain did not stop. My cousin, a ‘maulana’ (religious leader) recited verses from the Holy Koran, wrote it on a piece of paper and put the paper into a fire. The man who cast spells on me came screaming over to our place as he felt the fire of the prayer on himself. The culprit said, “I don’t know, I made a mistake; I just do this when I see pregnant women. When I saw her I chanted a bad prayer on sand and threw it upon her. Once I ruined the cow’s milk so that nobody could drink the milk!” Two other pregnant women died because of him. After the confession that day, the ‘maulana’ put an amulet around my leg and the baby was born immediately. However, when the baby was born she appeared dead but we realised she was only very weak. Now she is as healthy as anyone in the family.

Three main points emerged: first, denial of medical care led to a misdiagnosis of the causes of prolonged labour which in turn reinforced beliefs in the supernatural world. Second, denial of medical care compelled women to seek indigenous care. Third, this sort of behaviour could put a woman’s life at risk.

In rural areas, seeking care from traditional practitioners is encouraged because of easy access, closer relationship and similar cultural understanding of the body, health and treatment. However, not all women passively believe in supernatural misfortunes. Changing attitudes can be situated between ‘traditional values’ and ‘new cultural models’ as women compromise. A woman stated, “After my baby was born, I put a ‘loha’ (iron) in my hair and tied it back for 40 days. My mother wanted me to follow all these things, but when she was not around I didn’t really follow it.” Health education promoted by NGOs and the government has played a significant role in changing rural women’s attitudes.

**Perceptions of Birthing Care**

Women’s health-seeking behaviour is influenced by their perceptions of a particular birthing care. Some of the concerns about BHC birthing care that do not meet their needs and expectations are highlighted here.

**Homely environment**

Women complain of feeling lonely and uneasy about remaining at the BHC despite previous visits for antenatal check. A typical comment: “I feel empty, uneasy and restless inside.” They want to be with their ‘people’ - family, neighbours and familiar surroundings. The sense of belonging lacking at the health centre discouraged women from accessing birthing care outside the home. Women maintained that clinics could not provide as much care as one’s home. Female paramedics engaged with caring and administrative tasks felt that a ‘supportive’ atmosphere was important for pregnant women. They suggested that increasing the number of female staff at the BHC and relaxing their work hours would ensure a ‘homely environment’ for birthing women.

**Environment of fear**

The hospital is perceived for treatment of ‘pathological’ phenomena where only sick individuals access care. Most women seek treatment from the BHC only when ‘something serious had happened’, thus causing distress and fear. In contrast, home birthing is perceived to be a ‘normal’ event and not associated with the same level of fear. Additionally, some pregnant women are reluctant to be seen in a ‘state of sickness’ and therefore avoid treatment at the BHC. A woman concurred, “I pray to God that my baby not be born at the BHC.”
Dissemination of information on childbirth and high-risk pregnancy has played a role in frightening women and their families into seeking immediate care irrespective of health status. However, information that conforms to cultural understandings still needs to be disseminated.

**Fear of instruments**

A common perception among the women is that they will be forced to undergo surgery if they gave birth in a health centre. Any instrumental deliveries which require incision either in the abdominal or perineal regions are known as sez or caesarean in rural areas. The instruments in the labour room, including medicines, scissors, saline set, oropharyngeal suction machine, frighten some of the women. A woman recounted, "In the labour room I closed my eyes in fear. I was scared of the glittering instruments. I heard them talking about scissors. I was waiting and thinking to myself - when will they cut my vagina." Earlier practices in hospital birth tend to make women think that unwarranted surgeries result in unnecessary pain. Unhealed surgical scars prevent women from carrying out routine household chores and also affect their sexual life. In addition, a cut in the perineal area during childbirth is considered a social stigma and those affected are deemed to have angohani (a defective body). Women fear for their social status when their bodies are 'defective' and counselling to increase women's knowledge and understanding of childbirth becomes imperative.

**Pollution**

Notions of blood, pollution and purity are inherent in cultural constructs of pregnancy and childbirth in rural areas. Women link notions of pollution and seclusion to the place of delivery particularly home birthing. During home births, women are secluded in a separate room - atur ghar (room of seclusion) - for at least seven days because they are considered choa or napak (polluted). People who touch the mother and baby are also considered polluted. On the other hand, women do not perceive female paramedics or ayahs (female birth attendants) who assist with childbirth at the BHC, as napak. This shows that notions are also constructed in a fluid manner and differ with places and people. Though pollution has negative implications, some women held that it enabled them to rest during that period and protected the baby from evil spirits.

**‘Lajja’/Shame**

Patriarchal interpretations of honour tend to place the burden of shame, purity and pollution on women in rural society. The cultural experiences of birthing are linked to issues of honour and shame and considered a taboo. Attitudes are gradually changing though with more women speaking candidly about their experiences and feelings. Many women view screaming during labour as shameful and particularly embarrassing if male members of the family or others find out about their behaviour. A husband might hesitate to take his wife to a BHC or hospital during an emergency obstetric situation as he is responsible for maintaining the family's honour in the community. Despite social rules regarding 'appropriate' conduct, notions of honour and shame are still flexible, particularly in life and death situations.

**Quality of Care**

Quality of care is relative as health providers and clients have divergent views. For a client, quality of care is primarily about the humanitarian dimensions of health care. Clients evaluate services based on providers' caring attitudes and time spent with them rather than their technical skills. In contrast, providers rate technical skills and availability of services as crucial factors for quality services. This section highlights different perceptions of quality of care.

**Behavioural issues**

Women's narratives revealed that issues such as caring attitudes, dignity, privacy and emotional support are factors that influenced the choice of delivery place. In home births, women are surrounded by family and receive special care; TBAs play a significant role in childbirth, particularly during delivery and in neonatal care. Women perceive joto (caring) as "the continual checking up of their body, receiving medications and staff regularly asking after their health." A number of the women who gave birth at the BHC spoke about the caring attitudes of the staff: “BRAC ‘apas’ are busy and cannot always attend us, but they take care of each patient, examine them and give medicines. I won't forget their care!” The caring nature of the BHC staff can be attributed to their rural backgrounds and experiences in community work. BRAC health workers are often regarded as family by the community. One woman, referring to a health worker, commented, “How rude and bad can someone be to one's
own sick family member?” BRAC’s training programmes have sensitised health workers to people’s needs irrespective of socio-economic status.

Treating a person with dignity was perceived as “having someone sitting close by, being attended to and not neglected, not making a person sit on a ripped mat and behaving well.” Women felt respected at the BHC clinic. A woman said, “We are poor and ignorant but BRAC ‘apas’ are ‘khub bhalo’ (very nice and treat us so well).” However, observations at the BHC also revealed incidents of misconduct directed towards poor rural women. A female paramedic rudely told a woman in the middle of labour, “You village woman, don’t you know the rules of delivering a baby? Push down when you feel cramps in stomach.” Surprisingly, some of the rural women believe that the good behaviour of staff depended on their own behaviour. This comment is illustrative: “I was always quiet and never bothered ‘apas’, so they were also nice to me. To gain respect, one has to behave well.” Despite BRAC workers’ good interaction with the community, underlying hierarchical class distinctions remain as health providers may be unable to empathise with rural women.

Notions of privacy are culture-specific; some women link it to shame: “You can’t show your private parts to others, but to receive proper care, one has to compromise.” In most cases, women felt intimidated when interacting with health providers at the BHC and were often afraid to express their feelings. Women felt uncomfortable lying uncovered on the labour table in front of unfamiliar faces: “In the labour room, the sisters removed my petticoat from the bottom. As I was trying to cover my private parts, they said that we were all women and there was nothing to feel shy here. Would you feel shy in front of us?” Although health providers were reassuring and sympathetic in this case, they clearly did not understand women’s notion of privacy. Some women felt privacy was assured during home births. A woman said, “There is more privacy at home and only two people are inside the room during labour.” However, this contention is debatable as other women maintained, “Neighbours create problems by trying to peep into the labour room. The surrounding area becomes crowded with gossiping people.”

Women appreciate the constant reassurance of female paraprofessionals during childbirth. Many women prefer to remain silent during labour as screaming is perceived as ‘uncivilised’ behaviour: “What will other people think if one shouts like an uncivilised person? What do you expect from them if you do not behave yourself? Even a ‘dhaitani’ gets annoyed and scolds you bitterly for improper behaviour. To be well mannered, women should tolerate their pain.” Some women disparaged others who screamed or cried while giving birth. Despite BRAC workers’ empathy, there remain some gaps in service provision, the role of BHC staff in providing emotional support to birthing women is fairly adequate and reasonably sensitive.

**Skills of the BHC health providers**

Our observations revealed that while female paraprofessionals are capable of managing more than normal vaginal deliveries, the services at the BHC are adequate only for performing normal vaginal deliveries. During delivery, they tend to seek advice and suggestions from the male doctor who is not allowed to enter the labour room for socio-cultural reasons. A female paramedic remarked, “Our doctor always waits nearby when we conduct delivery. We inform him about the progress of labour. Whenever it is necessary, I ask his permission about the use of drugs.” The doctors, however, are not adequately trained in midwifery and have limited ability to advise on complicated cases. In addition, the BHC lacks trained personnel and sophisticated instruments for managing complicated cases. The staff felt the need for improved services, training on management of complicated cases and refresher training for capacity-building. One of the doctors spoke of the constraints at the BHC: “When a pregnant woman comes in with slight complications, we have no means or arrangements to help the woman. The instruments we have are good only for normal delivery. Episiotomy can be done but that’s about it!”

Despite paraprofessionals’ ability to manage normal delivery, their measures to prevent infection in the labour room were inadequate. For example, the instruments and rubber gloves used during delivery were not properly sterilised.
and maintained. Although health providers appeared to be aware of the need to maintain hygienic and germ-free procedures during birthing, in reality they seemed to be less concerned about maintaining such procedures.

Clearly, long working hours and excessive workload affected the type of care paraprofessionals were able to provide. The female paraprofessionals’ daily schedule was fairly hectic, beginning at 8:00 a.m. or earlier and continuing till 9:00 or 10:00 p.m., sometimes with only half-hour lunch breaks. Most of their weekends also appeared to involve BHC work. We observed female paraprofessionals working longer than 12 hours, particularly when a delivery occurred in the middle of the night. Although the utilisation of birthing care facilities was low, paraprofessionals remained busy providing curative care to outpatients and with administrative work of writing reports and records. They always appeared to be very tired and exhausted at the end of the day.

Referral to the district hospital

The BHC does not have technical capacity to manage complicated deliveries. When a woman needs blood transfusion and surgical procedures, she is referred to the district hospital. Some women and their families described feeling betrayed and angry with BHC staff when they were forced to transfer from the centre to the hospital. One woman remarked, “If BHC cannot handle complicated cases, they should not ask pregnant women to go there.” In most cases, transferring rural women to the government district hospital increased the trauma of the women and their families, as they were subjected to poor quality care. Although there were provisions for comprehensive essential obstetric care (ante-, intra- and postnatal care with provisions for surgical interventions and blood transfusion) in district hospitals, the quality of service was unsatisfactory. The following account of a paramedic highlighted the situation at the district hospital:

The woman developed retained placenta in the BHC. The female paramedic and the doctor immediately took the woman in a ‘tempo’ to the hospital with her family. She was taken to the emergency room, seen by a male emergency medical officer and sent to the labour room. The labour room was unclean and untidy and there were no doctors as most were busy with private practices. After the woman arrived she was placed on the labour table. Someone held the saline bag, as there was no stand to hang the bag. The untrained ‘ayah’ (female birth attendant) came near the woman. She touched her abdomen and put on her gloves. Then she put her hand inside the birth canal and removed the placenta. Neither the doctor nor the nurses entered the room at all. The ‘ayah’ asked the relative of the birthing woman to clean the labour table. After sometime the woman was moved to the ward where the emergency medical officer came to check whether blood transfusion had started.

The under-utilisation of skilled persons in the district hospital reflects not only an administrative failure but also a lack of accountability. The ayah’s active involvement in child delivery is frightening and paints a depressing picture of the state of government hospitals. By referring complicated cases from trained female paraprofessionals at the BHC to untrained ayahs at the hospital, rural women are placed in a more dangerous situation particularly during emergencies. If TBAs are trained and recognised to manage normal childbirth in the community where there is little or no medical help, then ayahs of the district hospital can also be given training to manage uncomplicated obstetric cases in the hospital.

Skills of the local TBAs

In rural areas, the skills of TBAs in conducting normal childbirth are held in high esteem. One woman said, “Kaida jane bole baccha dhore (she attends the birth because she knows how to conduct child delivery).” The TBAs’ judgment of labour is linked to decisions of how and where the delivery takes place. Some of the TBAs categorised labour into two states: ‘false’ and ‘true’. ‘False’ labour is ‘pain that comes and goes without any contractions’, whereas ‘pain that sustains with increasing contractions’ is ‘true’ labour.

When a TBA feels that true labour has started, she prepares for the birthing process. A woman who had relied on a TBA said:

The ‘dhaitani’ follows certain norms and rules. During my labour, she massaged oil on my tummy and shook my body at intervals by holding my waist. She told me that the baby would move down now. She did not permit me to lie down, I had to walk to bring the baby down. She checked my birth canal after washing her hands with soap and water.
After a couple of hours the baby was born. The ‘dhaitani’ did not make me feel distressed. She did not mishandle my uterus. She was very sensible and never tried to go beyond her capacity.

It appears from the description that the woman appreciated the TBA’s knowledge and skills and was also aware of her limitations. While this particular dhaitani washed her hands before inserting them into the woman’s birth canal, most of them do not follow such practices. Despite emphasis on safe delivery in practices in TBA training programmes, some TBAs still insert their unwashed or unprotected hands into the birth canal. Rural people consider the use of gloves an ‘extra expenditure’ and as their understanding of cleanliness is not related to washing hands or using sterilised gloves, following sterile procedures is not a serious concern.

None of the TBAs admitted to mismanaging delivery; instead, a few of them shared their experiences of coping with difficult births. One TBA, known for her competence and efficiency in the community, narrated how she conducted a delivery for her daughter who had a transverse lie. Although in this case the TBA succeeded in doing an external version (rotation) of transverse lie, incorrectly conducted external versions can have serious consequences. Here is a tragic story of a TBA’s mismanaged delivery:

The girl was hardly 16 or 17 years old. She was taken to her natal home during late pregnancy and had a terrible time during labour. The ‘dhaitani’ was her aunt and the family had considerable trust in her. The ‘dhaitani’ used all her skills but the birth space was so narrow that the baby could not come out. She injured the foetal head with her dirty nails and the baby’s head became putrid and foul-smelling. The girl was quickly taken to the BHC, but they refused to admit her because of their lack of skills in handling such a case.Sadly, the girl delivered a dead baby later in the hospital. This kind of ‘dhaitani’ should be condemned and so should the family.

These incidents highlight two crucial but differing questions. First, how can we appropriately use and incorporate some of the indigenous skills of TBAs? The earlier claim of the TBA’s expertise in handling the situation of the transverse lie attests to such skills. Second, how can some of the more dangerous practices, such as unsafe methods employed, be stopped given the trust and reliance on TBAs for child delivery in rural areas? While it is important that the positive practices of TBAs should be encouraged, unsafe practices need to be prevented by creating awareness amongst the TBAs and in the community.

Gender of health providers

The gender of a health provider is an important factor for rural women and their families in choosing a place of delivery. Because all providers working with maternity care at the BHC are female, women and their husbands do not hesitate to seek care. In rural society, the presence of a male doctor during delivery is considered sinful. One husband commented, “A man seeing a woman’s body not only results in sins of the wife but also of the husband and the family.” A woman who visits a male doctor is said to be shameful and brings dishonour and disgrace to the family. Such perceptions adversely affect pregnant women from seeking medical care. However, social rules and norms become flexible if a woman is in a critical condition. A woman who had retained the placenta and sought care from the BHC said, “I was about to die and had to compromise the gender of the health provider. A male doctor examined my private parts. I come from a very religious family but had no choice.” Such understandings of religion and gender impact on women’s health-seeking behaviour and have implications for health care. Heeding women’s voices on the need for female doctors during birthing care cannot be stressed enough.

Posture during childbirth

Paying attention to posture during childbirth is imperative for women’s active participation in birthing. For generations, village women have practiced the kneeling or squatting position when giving birth. Like most formal health centres, the lying down position is practised at the BHCs. Rural women claimed to feel more comfortable in the kneeling or squatting position during labour as they can push down with greater force. A woman commented, “Previsouly I delivered my baby in the kneeling position but at the BHC I had to lie down and it was difficult for me to push. I hesitated to ask them to allow me to sit because they may not like it.” Privacy related to posture is an important concern as well. Women feel that their privacy is better maintained in their preferred position, as their private areas are not exposed to others.
Some of the women who had delivered at the BHC were uncomfortable and hesitant to use their services in future. Other women who had heard of the lying down position practiced at the BHC were also reluctant to use the services. A woman noted, “I can’t even think of giving birth lying down on the bed. How is it possible? How do people push down at this position? I don’t think I would be able to deliver at the BHC.”

The indigenous posture of kneeling or squatting during childbirth is safe and feasible to incorporate into biomedical practices. Adopting the indigenous posture of birthing at health facilities will also recognise rural women’s needs during childbirth.

**Access to information**

A number of studies including this research indicate that although BHC workers provide information to clients, some glaring gaps exist (Afsana & Mahmud, 1998). Some women appeared to be unaware of neonatal care, immunisation and safe hygienic practices. Observations at BHC revealed that women and their families were not clearly informed about the need for various examinations or about the progress of labour. Consequently women and their families were left worrying about the impending birth. Many women feared that the birth would require surgical intervention. We found cases where the women and their families were not informed about the condition of the mother and baby. Female paraprofessionals were more absorbed with the clinical aspects of service delivery and appeared to be unaware of the importance of providing such information immediately. This can be partially attributed to the lack of training in behaviour and communication issues. Patients’ rights to information are continually debated in the medical establishment to improve the quality of care, yet in reality they seem to get less importance.

**Costs**

The cost of health care is an important concern as a majority of the women feel that the cost of having a child at home is insignificant. Paying a TBA is not mandatory although poor women usually give food or clothes instead of cash. For even poorer families, such basic expenses are difficult to afford. At the BHC, the basic cost of childbirth is from US$2.50 - US$3.50 (Tk.175 to Tk.275), which is much lower compared to other hospitals and clinics. Although government hospital services are free, the hidden costs for medicines and travel for patients and attendants are very high. Most women and their families are therefore reluctant to spend money on something perceived to be a natural event that can take place at home with negligible expenses. Not surprisingly, rural women felt that only in the event of an emergency - a ‘complicated’ birthing case - was it worth spending their money. Responding to a query about whether women would be keen to utilise BHC services if TBAs were unavailable to attend to the birth, a woman noted, “Please don’t utter the name of BHC. I don’t have any problems. I don’t want to worry about going to the BHC for treating my problems. Will you pay the money if I need to go there?” The worries of a potentially ‘complicated’ childbirth and the unaffordable costs of medical care made women even more reluctant to seek services from outside the home. In spite of economic constraints, women did not expect free services from the BHC. A woman remarked, “Certainly BHC can’t give free services. It’s their income.” The staff, aware and sympathetic to the plight of poor patients, did not turn them away in emergencies but worked out an informal system to assist them. There was a case at the BHC where a poor family was struggling to meet costs. The staff decided to hire the husband as a night watchman so he could earn extra money to pay for his wife’s treatment. In certain cases, service charges were waived. Even then, poor women are not keen to go to the BHC for normal deliveries.

**Distance**

Distance to the health facility and mode of transport were two other factors that influenced women’s access to health services. The mode of transport chosen depends on the distance to the health facility, financial capacity of the family, availability of vehicles, and the condition of the pregnant women. The local automobile - tempo - was usually taken by affluent clients, whereas the cycle van (three-wheeler flatbed vehicle) or rickshaw (three-wheeler upright vehicle) was used by poorer villagers. Even those who lived two kilometres away from the BHC found difficulties in accessing transport. One woman narrated:

> I had labour pain for about three days. The previous night I was not feeling well and was exhausted. My brother-in-law wanted to take me to the BHC. Where will you get transport at night? We had to wait till sunrise. The following morning my family rented a ‘tempo’ that took me to the BHC.
A doctor at the BHC also emphasised the problems related to geographical access:

_In my area, sometimes patients travel almost 18 kilometres. Even if a ‘tempo’ is available, there can be problems bringing a patient to the hospital, more so when the patient has complications, because there is no particular arrangement for it._

Therefore any geographical distance can be an obstacle to access health care during childbirth, particularly when transport is unavailable.

**Power, Maternity and Health Care**

Hierarchies of knowledge and power either at home or at the health centres influence decisions on where and whom women should go to for childbirth. Indigenous knowledge of childbirth is often devalued or ignored in favour of ‘legitimised’ western biomedical practices prevalent at health centres and hospitals. These understanding and hierarchies of knowledge have implications for the way in which power is exercised over people who are perceived as either subjects/agents or objects/patients (Hobart, 1993).

**TBAs and women in birthing experiences**

Rural women are usually the main decision-makers for intra-household matters and therefore seeking health care for pregnancy inside the home is their domain of concern. Female kin decide and choose which TBA will assist in the birthing. TBAs play a special role in home birthing and have total authority over birthing women’s bodies during childbirth. Even with this authoritarian role of the TBAs, the role of the birthing women is given due importance and recognition. Most rural women and TBAs belong to a similar socio-economic class. Their mutual respect and familiarity with one another create an equal relationship. This is not the case with medical practitioners.

Given the increased medicalisation of childbirth, rural families’ absolute dependence on TBAs’ knowledge has decreased. Women and their families tend to immediately seek care from a local doctor, BHC or a hospital if a TBA fails to demonstrate her expertise. There is also a growing realisation among TBAs that they are gradually being displaced from their traditional base of authority. A TBA saddened by the changing attitudes among some rural families remarked, “Once a pregnant women decided to go to a clinic after prolonged labour. I felt bad that she did not have any faith in me. Trust is very important in childbirth. Breach in trust may affect the childbirth process.” An inevitability of modernising influences is that some rural women, particularly the more affluent and educated, are changing their ‘traditional’ views on childbirth. As one woman concurred, “I can’t think of having my baby delivered by a ‘dhaitani’. The doctors have knowledge about human body. I am sure they won’t harm me and my baby.” TBAs are not only devalued for their lack of knowledge but also for belonging to a low socio-economic class.

The influences of modernity, increasing community campaigns about pregnancy risks and the availability of modern health care facilities are stripping power away from the hands of the TBAs. They have been somewhat marginalised by the introduction of medical knowledge. Some TBAs appear to have lost confidence in their skills; they point out their limitations in managing childbirth complications and also emphasise the importance of having strong referral linkages with the BHC. In addition, they concede to carrying out a balancing act to serve the community. Some of the TBAs deliberately adopt newly-introduced biomedical practices for child delivery, such as the use of steel blades instead of basher chachi (bamboo blades). Clearly, the increased authority of biomedicine has, to an extent, eroded the authority of TBAs.

**Biomedical realm and health care provision**

When women access medical care at a health centre or hospital, they automatically come under the power and knowledge of medical practitioners and lose control over their selves and become ‘patients’. They have to submit to a process where their bodies are examined, weighed and operated on. One woman’s experience at the BHC illustrated the above points:

_The woman was lying on the bed looking anxious. Without informing her, a nurse removed the sari from her belly and examined her body. The woman’s mother was also in the labour room and asked about foetal movement. The nurse did not respond to the mother’s question immediately. She completed examination of the patient’s body and then said, “The baby is alright.” Her mother was still anxious and asked her daughter whether the baby was moving. Later that night when_
she was taken to the labour room again, the woman still looked anxious. She was put on the labour table and they started intravenous fluid without giving any explanation. Then the nurse examined her vagina, without informing her. Monitoring continued but the family was not informed about the progress of labour. The woman’s mother (who was outside the labour room) became very upset and started crying. At midnight, the baby was born with breathing problems. None of the staff informed the family about the condition or sex of the baby till later.

Here the woman became a ‘passive object’ during her birthing experience. The existing hierarchical relationship results in an unequal encounter between women and health providers, thereby discouraging women from seeking formal care. The top-down approach in a biomedical establishment runs contrary to the more horizontal and equal relationship between women and TBAs during home birthing.

**Decision-making and family role**

Families influence decisions made on childbirth; rural men in particular are the prime decision-makers in extra-domestic activities. Women’s power to make extra and intra-domestic decisions depends on their age and the dynamics prevalent in marital and household relations. As birthing care is within the domestic domain and seen as women’s business, pregnant women are able to decide whether or not to have a TBA assist with childbirth. Furthermore, because the costs for TBA services are minimal, women are given the autonomy to decide. Within this context it is still debatable whether women really wield power over the home and household matters.

This study indicated that woman’s education and economic status have a positive impact on their decision-making role. While poor and illiterate women are under the absolute control of family members, literate or financially independent women are able to exercise their will to some extent over family members, including husbands. One woman pointed out, “My husband and I decided to have the childbirth at a clinic. But my in-laws were not at all happy when they heard I am going to a clinic.” Power relations can change when women are socially and economically empowered.

Social factors of *pardah* (veiling), shame and honour make women more vulnerable and restrict their movement outside the home. In the case of obstetric emergencies, delays in seeking medical care are not necessarily related to only notions of *pardah* and shame. Financial constraints and lack of awareness about pregnancy-related complications prevent women from accessing timely care at the BHC. Consequently, women’s access to birthing care tends to be accorded low priority in the power play for control within a household. The role of government and development agencies, particularly BRAC, in improving the socio-economic status of women is crucial to increase their access to health care and changing power relations within the family and community.

**DISCUSSION**

This study attempted to explore the extent to which the BHC was gender-sensitive to rural women’s needs and expectations during childbirth. The services provided at the BHC appeared to be fairly sensitive to rural women’s needs. However, critical comparison of women’s perceptions and experiences of home births and BHC maternity care raised significant issues. Women sought care according to their understanding of normal versus complicated birth. Childbirth was understood to be a normal and natural event and BHC care was sought only when ‘something serious happened.’ However, the BHC was established to provide care during normal birthing which most rural women think should happen at home. The lack of comprehensive services at the BHC ignored rural women’s understandings of normal and complicated birth which played a major role in influencing decisions on birthing care. Therefore it is important to upgrade services and skills at the BHC.

Health-seeking behaviour even in emergencies was influenced by cultural factors particularly belief in the supernatural. As pointed out earlier, such beliefs were reinforced when medical treatment failed. Factors that made women reluctant to seek care at the BHC included the lack of homely environment, fear of instruments and fear of getting a defective body because of medical intervention. Rural women also reported feeling a sense of shame or lajja when they sought medical care as villagers, particularly men, came to know about their pregnancy. Although most BHC paraprofessionals were from rural
areas as well, none were able to adequately empathise or understand the concerns and worries highlighted by the women.

Caring attitudes, dignity, privacy and emotional support were other factors that influenced women’s use of formal health care. While BHC staff communicated fairly well with the community, research observation identified several gaps in their behaviour towards rural women. Significantly, rural women expressed their gratitude to the BHC health providers for their caring attitudes and dignity shown during delivery. Evidently their understanding of dignity was different from that understood by the researchers. Given their marginalised background, these women had little expectations of quality health provision. Therefore, whatever little the BHC health providers were able to do for women seemed to meet their satisfaction. Privacy, however, was not well maintained at the BHC. This could be due to gaps in the understanding of local cultural practices and the disparaging attitude demonstrated towards the poor.

While female paraprofessionals neither sought permission before examining birthing women nor offered explanations for what was done to women’s bodies, they constantly reassured the women during delivery and allowed female kin to enter the labour room. Their sensitivity to women’s emotional needs was mainly garnered from what they had observed and heard about home birthing practices. Steps were taken to conduct normal vaginal delivery successfully while any mishaps were brought to the attention of higher authorities.

While the issues raised here seem minor, they still prevent rural women from accessing care. Training, including refresher courses, is important to sensitize BHC staff on communication and behaviour. It is crucial to have skilled and trained health providers in obstetric care, for preventing and reducing deaths and complications related to childbirth. TBA training is important in this regard as rural women rely on them for maternity care. However, a study found that that even after formal training, TBAs tend to follow their own practices during child delivery (Goodburn et al., 2000).

This study maintains that to effectively use indigenous skills in the community, culturally-appropriate training should be emphasised and positive practices of TBAs incorporated in training programmes. Effective supervision and building community awareness about the possible risks involved in some hazardous practices of TBAs will also strengthen safe motherhood initiatives in the community. Female birth attendants at the BHC can be trained to manage uncomplicated obstetric cases in the labour room, so they can eventually work more effectively in the community.

The BHC seems sensitive to some issues voiced by women depending on how feasible it is to be incorporated. Employing women as the immediate health care providers in child delivery is a significant issue for rural women. Yet, the prime health provider at the BHC is a male doctor. Despite women’s preference for female health providers, it was observed that women compromised their understanding and accepted the presence of a male doctor during emergencies. However, the thought of a male doctor attending the childbirth event created reluctance among women and their families to access formal health care.

Rural women are comfortable in particular birthing positions that are not difficult to incorporate into the BHC. However, their preferred choice of childbirth positions is ignored as biomedical practitioners are more comfortable delivering a baby when a woman is lying down. Incorporating the indigenous posture of birthing would enable the BHC to acknowledge rural women’s needs and practices.

Without over-idealising home birthing, the comforting environment of home delivery in comparison with the prevalent technical atmosphere in formal health care settings needs to be recognised. The acknowledgement of women's active role in childbirth experience will allow for the sharing of knowledge and information, reduce communication gaps and increase the social acceptability of biomedical health practices.

Costs and distance are also factors affecting rural women’s utilisation of the BHC. It was found that most women had no control over their incomes as husbands or mothers-in-law are the main decision-makers on birthing care. Their less important role in income-earning also caused delays in being taken to the BHC. It is also difficult to justify paying for childbirth when home birthing is perceived as a natural event practised for generations. Distance and unavailability of transport during emergencies also limit access and raises the
need for alternative transport systems, for example rural ambulance services which can rely on locally-available and cost-effective transport such as vans and tempos. Empowering women socially and economically will indeed enhance their rights to birthing care and contribute to reducing maternal deaths and complications.

**CONCLUSIONS**

Three main issues from this research, which have implications for gender-sensitivity in maternity care, are discussed here.

**Concepts of Gender-sensitivity**

An analysis of women’s birthing experiences revealed how concepts of gender-sensitivity can be identified and applied in maternity care. Since unmet needs in maternity care occur as a result of unequal gender relations, the BHC needs to address factors that hinder women’s access to maternity care. A main issue raised by women in the study is the lack of comprehensive maternity services including inadequate access to information, and a lack of caring attitudes among health providers that deprives women of their dignity, privacy and emotional support. Other barriers to accessing formal health care are fear of hospitals and medical instruments, and perceptions of getting ‘defective’ bodies because of medical intervention. In addition, financial constraints and geographical access also hinder women’s utilisation of health care. Women identified the need for women health providers and preferred the use of indigenous birthing positions as factors that would encourage their use of the BHC. These issues should be addressed in the BHC to improve women’s access to maternity care and provide gender-sensitive facilities and services that not only acknowledge and meet women’s expectations and needs but also consider the impact of unequal gender and social relations in their lives.

**Marginalisation of TBAs**

TBAs are the primary caregivers during childbirth in rural areas. However, their role has been marginalised after the failure of TBA training programmes and the introduction of emergency obstetric care. This study found that TBAs are still respected in the community. The existing trust and reliance on TBAs can be further enhanced by including them in training and awareness-raising to address the dangers of unsafe practices during childbirth.

**Use of Qualitative Approach**

The strength of the study lies in the use of qualitative methods for assessing gender-sensitivity in the BHC maternity care. By bringing together women’s voices, providers' perspectives and researchers' experiences, a distinct picture of birthing care has emerged. While women were the focus and their perceptions and experiences raised important issues, health providers’ views offered a different perspective and researchers’ experiences filled the gaps. Qualitative methods of enquiry lend themselves to such a study as information gathered from various actors enabled in-depth analysis based on their ‘voices’.

It is a challenging task to address issues of gender-sensitivity in BHC maternity care. In conducting the research, the need for improvements in quality of service and address gender concerns became evident as women recounted their birthing experiences and expressed concerns over services. Challenges of translating concepts of gender-sensitivity in health care into actions still lie ahead. This paper argues that to increase women’s access to gender-sensitive maternity care, serious and long-term commitment become imperative and multi-pronged efforts are necessary. The study underscores the need for more qualitative research on rural women’s understanding of reproductive health and childbirth. More ethnographic studies could provide crucial information on gender relations and socio-cultural practices that have an impact on women’s access to maternity care.

**RECOMMENDATIONS**

The recommendations made here will enable the BHC to implement gender-sensitive birthing services and therefore enhance women’s access to maternity care. Strategies are also identified to raise awareness about gender-sensitivity in birthing services.
• **Upgrading of BHC services.** To meet rural women’s needs, BHC services could include provisions for surgery (construction of operation theatre and hiring outside obstetricians for caesarean cases), blood transfusion services (access outside services) and laboratory support (to facilitate operations).

• **Training of the health providers.** Training could cover midwifery and the need for aseptic practices during childbirth. Cultural aspects of childbirth and addressing rural women's understandings of childbirth and birthing care need to be emphasised. Sharing information with clients and their families should be encouraged and women's rights to receive quality services stressed. Health providers could be given support to form an interactive problem-solving group to discuss aspects of gender-sensitivity. Incentives for performance can include scholarships for short and long courses either at home or abroad.

• **Acknowledge indigenous practices.** Health providers could encourage women to adopt indigenous birthing positions during childbirth at the BHC.

• **Creating awareness.** Rural women and their families can be made aware of women's rights to obstetric care and quality services including their control over birthing experiences. Information on pregnancy and childbirth including complications needs to be communicated in appropriate ways. Steps could be taken to demystify medical practices.

• **Affordable health costs.** Health subsidies are needed to make health services affordable and acceptable. Rural health insurance schemes could minimise or resolve problems related to huge expenditures during childbirth. People could be encouraged to save for birthing care. BRAC could waive costs by mobilising resources from budgetary allocations reserved for the poor in emergency situations.

• **Ambulance services.** Ambulances can be arranged by using local transport such as tempo and rickshaw-van. The service could be managed and supported by the community. For example, the family of a pregnant woman could be made aware of using it in case of emergencies. BRAC could also have its own means of transport.

• **Training and remuneration of birth attendants.** TBA training programmes need to be remodelled to address the understandings of the body, pregnancy and childbirth. Indigenous practices that are safe can be improved upon and incorporated in the training. Supervision of trained TBAs would ensure effective implementation of gender-sensitive maternal care. Pooling of resources from the community in the form of rural health insurance schemes can be introduced from which remuneration for TBAs could be arranged.

Strategies to mainstream gender-sensitivity in maternal health care are as follows:

• Policy makers and planners could be made aware of gender-sensitivity through dialogue, forums and meetings. Women’s groups and NGOs need to sustain lobbying efforts for increased budgetary allocations towards women’s health care. Partnerships between government and non-government sectors in maternity care research and implementation could be fruitful.

• Information dissemination on the importance of gender-sensitivity in health care can be conducted in various ways. The outreach of radio, television, newspaper and popular theatre can be tapped. Medical education and training curriculum could specifically address women's perceptions and cultural practices of childbirth.

• Women groups could lobby for the inclusion of indigenous health practices and traditional birth attendants in mainstream maternal health care.

### ACTIVITIES AND OUTCOMES

The following are ongoing efforts at BHC based on the recommendations made by this research.

• Comprehensive obstetric care at the BHC is starting in stages.
Feasible sterilisation procedure has been adopted at the BHC in order for caesarean operations to be carried out.

Despite budget constraints, funds were made available to provide comprehensive obstetric care to poor rural women after appealing to the executive director and programme heads of BRAC.

BHC health providers received further training on midwifery and hands-on training in operation theatre.

Hiring of a female physician for the BHC, and ensuring that the paraprofessionals at the BHC are all women.

There will be budgets in the new BRAC programme for the poor to ensure that poor women receive better access to maternity care.

Workshops on gender-sensitivity have been organised for health providers after a training module was developed.

Quick laboratory procedures have been adopted.

BRAC is considering a rural ambulance service for poor women.

REFERENCES


ABBREVIATIONS

AIDS Acquired immunodeficiency syndrome
BHU Basic health unit
BHC BRAC’s health centre
BRAC Bangladesh Rural Advancement Committee
CBD Community-based distribution
CEDAW Convention on the Elimination of all forms of Discrimination Against Women
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FWV</td>
<td>Family welfare visitor</td>
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<td>HHH</td>
<td>Heads of household</td>
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<td>HIMS</td>
<td>Health information management system</td>
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<td>HIV</td>
<td>Human immuno deficiency virus</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IEC</td>
<td>Information education communication</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>IMR</td>
<td>Infant mortality rate</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>IUD</td>
<td>Intra-uterine device</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<tr>
<td>MMR</td>
<td>Maternal mortality rate</td>
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<tr>
<td>MO</td>
<td>Medical officer</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>POA</td>
<td>Programme of Action</td>
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<td>QOC</td>
<td>Quality of care</td>
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<td>RH</td>
<td>Reproductive health</td>
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<td>RHC</td>
<td>Rural health centre</td>
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<td>RR</td>
<td>Reproductive rights</td>
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<td>RTIs</td>
<td>Reproductive tract infections</td>
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<tr>
<td>SR</td>
<td>Sexual rights</td>
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<tr>
<td>STD</td>
<td>Sexually transmitted diseases</td>
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<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
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<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Fund For Population Activities</td>
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<tr>
<td>VAW</td>
<td>Violence against women</td>
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**NOTES**

1. An administrative unit covering a population of 250,000.
2. One male and one or two females.
Women's access to reproductive health services in a public hospital in the Philippines

Rosena Sanchez and Regina Ingente

INTRODUCTION

Gender is an important factor to consider in designing, managing and delivering reproductive health services. Yet, gender may also be the least understood characteristic in terms of how women and men’s health needs differ and how these differences can be understood. Health providers, programme managers, policy makers and donors are increasingly aware that gender is a critical element in the design management and implementation of reproductive health programmes, and ultimately in the success and impact of these programmes. Reproductive health services that are gender-sensitive will encourage increased use of these services and promote sound reproductive decisions (The Manager, Vol. IX, No. 34, p. 1). For the past ten years, women’s groups in the Philippines have advocated for health programmes to be more accessible, more culturally and gender-sensitive and of better quality for women. Despite many initiatives by government and non-governmental organisations, indicators of women’s health status in the Philippines still show many unmet needs.

In many parts of the country, adequate service availability in critical components of women’s reproductive health such as maternal health care, cancer screening, sexually transmitted disease/HIV/AIDS, psychological health, and violence against women are lacking or absent. In its section on Women and Health, the Beijing Platform for Action acknowledges the poor situation of women’s health. The Beijing Platform for Action also recommends specific actions to be implemented primarily by government organisations. Among the recommendations are to:

- design and implement, in cooperation with women and community-based organisations, gender-sensitive health programmes, including decentralised health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural
women and women with disabilities and the diversity of women’s needs arising from age, socio-economic and cultural differences among others; • redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user’s perspectives; and • ensure that all health services and workers conform to human rights standards and to ethical, professional, and gender-sensitive standards in the delivery of women’s health services.

This study is conducted with the aim of assessing women’s access to government’s health programme, in this case, a tertiary hospital.

COUNTRY CONTEXT

Status of Filipino Women

Filipino women constitute half of the nation’s population. Filipino women have longer life expectancy than men (by about three years) and their educational attainment and literacy exceed that of men. Other indicators of their status are less favourable.

Health, Nutrition and Domestic Responsibilities

The 1987 National Nutrition Survey found girls 13 years old and above had higher rates of anaemia than boys of the same age. In addition, about 17 per cent of pregnant females aged between 13 and 20 years had iodine deficiency compared with only one per cent among males of varying age groups (National Nutrition Council 1987 as cited in Osteria et al., 1997).

Education and Literacy

The 94 per cent literacy rate of women 15 years old and above is at par with the corresponding 95 per cent literacy rate among Filipino men. However, there is a tendency for most (up to 80 per cent) women to pursue education courses in college compared with only 19 per cent of male college graduates. Instead, men tend to dominate the engineering and law professions. Teaching is a low-cost college course that commands a correspondingly low-income stream upon employment, whereas engineering and law courses are more expensive but, eventually, command higher future income (Country Population Assessment, 1999. p. 29).

Livelihood and Employment

Some data reported in the Country Population Assessment showed that there is only one woman for every three persons in the labour force and that there are two women for every five unemployed persons. Despite recent changes in the definition of labour force participation and employment, women’s informal sector activities are still not entirely captured in labour and manpower surveys.

More working men tend to hold executive positions in the private sector and in the bureaucracy, whereas more women hold lower clerical positions. In terms of average income, in 1998, women earned about 50 centavos for every peso earned by men. This large income differential may be due to these facts: women spend a shorter time in regular employment; they tend to perform more unpaid household activities; and they also take lower paying jobs in the informal sector to accommodate their childbearing and child rearing activities.

Political Participation

In 1993, the portion of elected local officials that were women ranged from three per cent of city mayors to 12 per cent of Sangguniang Bayan (National Council) members. As of 1998, the proportion of women legislators and officials elected to Congress was only 9.6 per cent (20 out of 208). Several women elected to national and local public offices were either related or associated with powerful men in politics. On the whole, women occupy 15 per cent of the total elected positions showing male dominance in Philippine politics (Women and Men in the Philippines: Statistical Handbook, 1999. pp. 102).

Reproductive Rights

For many women, reproductive rights are realised when they become pregnant, carry to full term, deliver and raise the infant. The disadvantaged position of
Filipino women is evident from the 1996 survey data of Zablan (1999 Country Population Assessment) where men were identified as the final decision-makers in most areas of joint decision-making among couples, including sexual relations, childbearing and child rearing. When men weigh in on these decisions, they often fail to recognise women’s rights to determine whether to have sexual relations, get pregnant and use contraception. Consequently women are subject to unwelcome sex, unplanned or unwanted pregnancies and high-risk births.

These problems become compounded for low-income rural women. A key research finding of a three-year study on reproductive rights by the Philippine team of the International Reproductive Rights Research Action Group (IRRRAG) is that such women negotiate “for reproductive and sexual entitlements rather than passively accepting their lot”. Women usually “engage in trade-off”, for example, they reportedly submit to unwanted sex to obtain some household help, elimination of domestic conflicts and the chance to find work outside the home or participate in meetings. Significantly, women view men’s participation in housework and in fertility management not as concessions from men but as a part of women’s reproductive rights. The study also showed that the decision to use contraceptives or carry a pregnancy to term is theirs and not that of spouses, doctors or church authorities. Far from sustaining the idea that Filipino women do not value their ability to control their reproduction, the study suggested that the concept of reproductive rights dominates women’s perceptions of sexuality and gender roles (Fabros, 1998, p. 251).

**Maternal Health**

In 1995, regional and provincial estimates of maternal mortality by the Technical Working Group and Child Mortality of the National Statistical Office and Coordinating Board revealed some improvements. For the country as a whole, the maternal mortality rate (MMR) was estimated at 180 maternal deaths per 100,000 live births.

The high incidence of high-risk births, inadequate prenatal care and lack of information and means to manage complications in difficult pregnancies accounted for much of the increased risks of death during pregnancy and childbirth. The major causes of maternal deaths are postpartum haemorrhage, eclampsia and severe infections. In most cases, 58 per cent of maternal deaths occur within a day of admission in medical facilities, indicating late medical attention to complications of deliveries as a major cause.

Prenatal care is reportedly high in the country. The 1998 National Demographic and Health Survey (NDHS) reported that 86 per cent of births were facilitated by doctors, nurses or midwives, an improvement on the 83 per cent of births reported in the 1993 National Demographic Survey (NDS). The three main sources of antenatal care are midwives, doctors and traditional birth attendant (TBAs), in that order. More than two thirds of all births take place at home and more than half of these are assisted only by traditional birth attendants. Only 30 per cent of deliveries occur in medical facilities.

The same report also identified the most prevalent maternal morbidities during pregnancy to be vaginal bleeding, convulsion and high fever. During labour, common morbidities include long labour hours of more than 12 hours, massive bleeding, malposition, caesarean section and retained placenta. After childbirth, mothers have complications such as uterine prolapse, urinary incontinence, urinary tract infection, dyspareunia and vaginal discharge.

**Family Planning**

The same demographic and health survey showed that for the most recent period between 1993 and 1998, overall contraceptive use increased from 40 per cent in 1993 to 46 per cent in 1998; the use of modern methods increased from 25 to 28 per cent during the same period.

As shown by the data from the 1993 NDS and 1998 NHDS, the most important reason cited for not using any contraceptive method or for discontinuing the use of any method is ‘fear of side effects and health concerns’. It is not clear however to what extent such fears and concerns reflect social and cultural influences rather than actual biomedical risks. About one in five women reported a desire to space or limit children, yet did not use any contraceptive method to achieve this reproductive goal.
Prevention of Abortion

Reproductive health is under increasing threat to illness, injuries and even deaths arising from unmanaged or mismanaged complications of unsafe abortion practices among women seeking to terminate unwanted pregnancies. A recent analysis of hospital admissions due to post-abortion complications revealed about 400,000 induced abortions in 1994 in the Philippines (Perez et al., 1997). Indirect estimates of abortion rates showed Metro Manila with the highest abortion rate of 41 per 1,000 women aged between 15 and 44 and the lowest in the Visayas with 11 abortions per 1,000 women in the same age group.

RESEARCH FRAMEWORK

The International Conference on Population and Development in Cairo in 1994, the Fourth World Conference on Women in Beijing in 1995 and the fifth-year review of these conferences in 1999 and 2000 respectively, highlighted gender as an essential part of equitable, sustainable development. The conferences encouraged reproductive health programmes to examine gender issues that underline health problems, address women’s health needs throughout their life span, view sexuality as a positive part of a woman’s life, and address men’s responsibility in respecting women’s reproductive rights. The conferences underscored service providers’ sensitivity to gender concerns to improve the effectiveness of reproductive health services (The Manager, Vol. IX, No. 34, p. 2).

The agreements and plans of action from these global conferences called on all governments to contribute to the solutions, in part through health programme by developing requirements for gender-sensitive health services, obligating health professionals to contribute to equity and human rights in providing the services.

Although these conferences made significant gains in women’s rights, gender equality and reproductive health issues, Asia-Pacific health care systems remain insensitive to women’s health needs. Women suffer inequalities in health status and treatment despite the availability of modern medical technology and overall increase in life expectancy. Within the health care system itself, women face inequality in the roles they could play as health workers and in their opportunities to influence the formulation of health policies and the focus of medicine and health research (ARROWS for Change, Vol. 5, No. 3, 1999, p. 1).

Gender-sensitive health care perceives existing gender differences, issues and inequalities and incorporates these into strategies, actions and services to improve women’s health. An important aspect is that women, individually and collectively, are treated with dignity and respect, are able to make informed decisions, allowed to become equal partners in decisions about their own health care and allowed to contribute their views to health planning and research. A gender-sensitive, women-centred programme addresses individual interests, health, and population and development goals (ARROWS for Change, Vol. 6, No. 1, 2000, p. 1).

Women-centred basically means to consider the needs, experiences and issues from the point of view of women and incorporating this in the planning, implementation and evaluation processes of policies and programmes which affect women’s daily lives. Furthermore, it is important that mechanisms are built into the processes to ensure that women are able to articulate their concerns and that these are listened to and understood, and that there is concrete response or change (Research Meeting Planning, 1997, p. 20).

The research framework covers three major concepts of access, gender-sensitive and quality of care as measured by variables contained in the objectives of the study (Research Meeting Planning, 2000).

RESEARCH OBJECTIVES

The main objective of this research is to assess service provision at the Obstetrics and Gynaecology Department of a public tertiary hospital that are available to low-income women or other women, as to whether such services are accessible, gender-sensitive and women-centred. More specifically it aims to:

• explore the perceptions and experiences of women clients admitted to the hospital in terms of the following: access (reasons for choosing...
RESEARCH METHODOLOGY

Using qualitative research techniques, this study describes and analyses behaviour and culture of human groups as well as points of views of those being studied. As such, direct quotations are the basic source of data, revealing the respondents’ depth of emotion, their thoughts about what is happening, their experiences and perceptions, for example, with a particular programme being evaluated (Patton, 1990, p. 24).

This study was conducted in one of the tertiary hospitals in Mindanao, in particular in its Department of Obstetrics and Gynaecology. For reasons of privacy and confidentiality, the identity of the hospital is withheld. There are two types of respondents in this study:

- Women clients admitted to the Department of Obstetrics and Gynaecology.
- Service providers at the Department of Obstetrics and Gynaecology such as doctors, nurses and social workers.

DATA COLLECTION

Three main research tools were used to collect data, namely in-depth interviews, focus group discussions (FGD) and observations. These were used for both types of respondents. In addition to primary data, secondary data from the hospital was also used. The interviews were conducted in August and September 1999 while the focus group discussions were held in April and May 2000.

The two researchers – a social scientist and a medical doctor – coordinated the interviews and focus group discussions with the chief of hospital and other health providers who helped arrange the interviews with service providers. A female interviewer was trained and hired full time to conduct the in-depth interviews. She is a social work graduate and has worked for more than ten years in health and human rights NGOs in Mindanao.

In-depth Interviews

In-depth interview was used as the first and the main method of data collection. Different women were selected to gain insights of their admission experiences at the hospital. In selecting the respondents, the full-time interviewer examined the admission list at the obstetrics and gynaecology ward and selected the women based on such criteria as case history, residence and age.

The interviewer approached each target respondent and carefully explained the purpose of the interview. Privacy and confidentiality were assured and the use of tape recorder explained. Despite the explanation, a few women declined to participate in the study. The women were also interviewed in their residence at least ten days after discharge from the hospital. The interview lasted from one to two hours depending upon the nature and extent of information shared by the women.

Twenty women were selected for the in-depth interviews. Their experiences included 13 obstetrics cases (four normal delivery, one premature delivery, one caesarean section, two caesarean section with tubal ligation, three spontaneous abortion and two induced abortions and seven gynaecology cases.
(four ovarian cystectomy and three hysterectomy). The interviews included questions on socio-demographic characteristics, experiences and perceptions of service delivery at the hospital and problems encountered.

The nine service providers interviewed were five resident doctors, one consultant, one nurse and two social workers. Interviews covered socio-demographic characteristics, positive and negative experiences with clients, work conditions, extent of training in gender-sensitivity and problems faced in providing the needs of clients and their coping mechanism.

Focus Group Discussion

One focus group discussion was conducted for service providers (seven doctors and a nurse). It focused more on validating responses and exploring more issues and experiences related to the study objectives.

The results of interviews of both the clients and service providers were the basis for the focus group discussion guide questions. The focus group discussion was mainly to share the results of the interviews and obtain reactions and comments from the participants. The focus group discussion also allowed for further validation and exploration on issues, experiences and problems not raised in the interview.

Observations

The social science researcher, the medical consultant at the hospital and the full time interviewer recorded observations at the hospital. Their observations were done separately and at different times of the day to cover the emergency room, delivery and labour room, the ward, billing and social work office.

Socio-Demographic Characteristics of the Women Clients

Eight of the 20 women clients interviewed were within the age range of 20 to 24 years while five were within the 25 to 34 years range. Two were 17 years old while the oldest was 50 years old. Eighteen were married and eight had completed high school and the same number had reached college level. One respondent never had the chance to go to school. All married women had children, mostly one or two children while six had five or six children. Most of the women were Catholics. The women were selected by case histories and by area of residence. Eight women were residents of the city and the rest were from neighbouring provinces.

The women were employed as farm workers, vendors, storekeepers, waitresses and dressmakers. All husbands were older than the wives with more than half beyond 34 years. Most of the spouses were in the informal sector or in casual employment such as construction and odd jobs.

Profile of Service Providers

Of the nine service providers covered in the study, four were below 30 years and three were more than 40 years. All were Roman Catholic and six of them were married. Eight of those who were interviewed participated in the focus group discussion for service providers.

FINDINGS

Women's Experiences in the Hospital

Most of the women were admitted to the hospital for obstetrics care such as childbirth (both normal and caesarean section), though complications of pregnancy including spontaneous and induced abortion were also reported. Only one of the four women had an uncomplicated pregnancy. Three others had hypertension and obstructed labour while others had gynaecology problems requiring surgery like ovarian cystectomy and vaginal hysterectomy.

Access to health services

This section presents the women clients' views on access to the above health services; access being defined in terms of autonomy to seek health care as evidenced by reasons given for choosing the hospital, the waiting time endured, costs incurred and the distance from residence to hospital.
Reasons for choosing hospital
The main reason cited was the low cost or free service. Other reasons included referrals by service providers to other hospitals, availability of equipment and facilities, competence of doctors and proximity.

We are financially-constrained. Even if I preferred a private hospital, we could not afford it. We know it is free here because this is a public hospital.

It was highly recommended not only because the services are free but because it is fully equipped and has specialists.

To poor patients like us, we really have no choice but to go to the government hospital.

My sister gave birth here and she told me how congested the hospital was. At that time, patients occupied corridors and stairs. She also told me of the uncaring attitudes of the doctors. Despite all these, I was forced to come here. We cannot afford to go to a private hospital.

Waiting time
The focus group discussion and interviews for women clients included questions on the length of time they had to wait from arrival at the hospital until they received medical care. Most women felt the wait was unreasonably long before getting any medical attention. Two women from the focus group discussion shared the following:

I had bleeding and so we came here. It was 3:00 pm. My bleeding got worse. I thought I was going to faint. My vision was blurred and so was my hearing. They were conducting the interview for admission but I could hardly hear them, so my husband answered the questions for me. I was crying because I felt body pains. A doctor did an internal examination and it was painful. I was sent to the waiting area of the delivery room. They shaved me and gave me dextrose (intravenous fluids). I thought they would then attend to me but the doctors were all busy. Half of the delivery tables were occupied. They finally moved me near the labour room by twelve midnight, but only started curettage procedure on me at 3:00 a.m. It was 12 long hours before they attended to me.

We arrived at 6:00 p.m. at the emergency room. There was a queue, so I informed the doctor doing the admission interview that I was about to deliver (‘kaanakon na gyud ko’). But she told me to wait for my turn for the interview and internal examination (IE). After the IE, I was told to walk behind another pregnant woman in a wheel chair. I wished they had also put me in a wheel chair. I could hardly take another step when I reached the delivery room (DR). At the DR the doctors were angry because I had no admission papers. My husband hurried back to the ER to get my papers that they had forgotten to give us earlier. Soon after, I gave birth. It was around 9:00 pm.

One of them recounted the experience of a pregnant woman who decided to transfer to a private hospital:

One of the women waiting in the delivery room got her papers back and decided to transfer to a private hospital. I think this is a common occurrence where women, upon seeing that they cannot get immediate care, decide to move to another health facility and possibly a private one.

However, others just waited because they could not afford to go to any other hospital, particularly a private facility.

After the interview at the emergency room, they sent me to the delivery room. There I waited again for a long time because there were just too many women on the delivery tables and in the labour room. I think dilation and curettage cases had to give way for delivery cases.

I was feeling very weak and I think I fainted because I could not see anything (‘napalong ang panan-aw’). It was past noon when they got me out of the delivery room.
Cost

Because childbirth is considered natural or normal for women, most doctors think this is a condition for which families must be prepared. However, household incomes and purchasing power due to inflation have been declining as has government spending in general and for health care in particular. Consequently, the cost of medication and supplies is often high. Clients also incur other costs including transport and expenses for themselves and family members who care for them in the hospital.

One woman refused blood transfusion as her family could not afford to buy blood and other supplies. The doctor scolded her when her husband did not purchase the needed blood. The client’s husband had already incurred expenses for the purchase of medicines not available at the hospital. Significantly, the client and her husband could not understand why blood transfusion was needed for someone with high blood pressure (hypertension). This is a common confusion among Filipinos. A 34-year old woman with six children recounted:

The doctor asked me, “Why is it that until now, you still have not bought the blood?” I asked her, “Why do I need a blood transfusion when you said I have high blood pressure? I’ll just go home and eat vegetables.” My husband told the doctor we have been in and out of the hospital and that we had spent a lot on medicines, we could not afford to buy blood. She then asked us to sign a waiver freeing the hospital from any liability for problems arising from my refusal to have a blood transfusion. The simple truth is, I refused because we have no money. There is nothing more we can do (‘Wala na gyud mi’y mahimo’).

Almost all the women faced difficulties coping with hospital expenses and most had to borrow money to cover the expenses. While they paid very little upon discharge because of discounts given by the social worker, they had to spend a lot on medicines and supplies, particularly at the gynaecology unit.

A 17-year old rural respondent gave birth prematurely to twins and upon discharge, was prescribed antibiotics for her and the babies. However, the young couple could not afford the medicine and neither did their families offer any help. Less than a week later, the twin babies died. After the burial, the woman’s husband fell ill and was also admitted to the hospital. The couple felt guilty about the death of their first-born babies.

A 23-year old rural woman scheduled for a caesarean section forced herself to undergo normal delivery to avoid expenses:

I was told I needed to undergo caesarean section because the baby was too big for my size. They said I needed about 8,000 pesos (about US$178 at US$1= 45 pesos) for the blade, medicine and blood supplies. I was left in the delivery room because I did not have these supplies. I tried to avoid the operation because we had no money. So I pushed hard every time I felt the contractions. I also inserted my fingers inside my vagina (‘gikuhit-kuhit nako akong puerta’) and when I felt the baby’s head, I pushed even harder with all my strength (‘giutong ug maayo hinurot ang tanang kusog’). My baby was born nine pounds. I had long stitches because the baby was so big. They gave my baby dextrose because she swallowed some impurities. I am glad I did not undergo the caesarean, as it would have been very expensive.

Distance from residence to the hospital

Those living in remote areas with inadequate transport services are at a disadvantage. Often, women have to travel at great risks to reach the nearest medical facility. They also have to contend with ill-equipped health centres and are often referred to a tertiary hospital. Family members have to find ways to transport clients to the health facilities. A respondent suffering from prolonged labour was carried in a hammock at two o’clock in the morning for three hours on rough terrain until they reached town, where a tricycle brought her to a private clinic. After an hour’s observation, the clinic doctor advised them to proceed to the hospital. The husband had to borrow money from friends and relatives for transportation expenses. By the time they reached the hospital, the woman was unconscious. It had been 12 hours since they left home. The woman, a 45-year old mother of eight, who is a farm worker and illiterate, said:
When I woke up I was told I gave birth to a stillborn baby boy through caesarean section. My husband told me he also consented that I undergo tubal ligation since my pregnancies are getting more difficult. I felt very lucky to be alive but I felt very sorry for my baby. I did not go for prenatal checks at the health centre because it is very far. I was also worried that I was already ligated. My husband explained it was for my own good. He said he was afraid I would not make it the next time. I understand what he did. Now, I cannot do farm work because I have had two operations.

Evidently, lack of evenly distributed equipped health facilities, poor roads and long distances separating people from services, have serious consequences for women and their families. This is particularly so for poor women as illustrated by the above case where the husband had to borrow money for transportation expenses. Furthermore, the doctor's decision to do tubal ligation without the woman's informed consent is clearly a significant ethical issue that needs urgent attention. Another woman, aged 34, shared a similar experience when she was in her sixth pregnancy:

I rode in a 'kanga' (cart pulled by carabao or buffalo) in the middle of the night. After an hour, we reached the nearest medical facility in the poblacion, which is a private hospital. They attended to me and I was told I had complications from hypertension. After a while they told us to proceed to the nearby district hospital that refused us and referred us to this hospital. We were fortunate that the ambulance was available at that time. I was admitted unconscious. When I woke up, I learned that I had undergone caesarean section and tubal ligation.

**Gender-sensitive services**

The gender-sensitivity of the service was assessed using such variables as spousal support and consent for ligation, hospital bed allocation and emotional and other support given by providers. To a large extent, the section on interpersonal relations covered under quality of care addresses the gender-sensitivity of the health services as it describes the negative experiences faced by women which strips them of dignity and respect given the discriminative treatment from service providers.

**Spousal consent for ligation**

Two rural women underwent tubal ligation during caesarean section. Their husbands made the decision as they were unconscious when they reached the hospital. Although one woman had had initial discussion with her husband about ligation, she did not expect it to happen so soon. Neither did she expect to undergo caesarean section due to obstructed labour. The other woman who had six children was shocked to find out her husband signed the consent form for her ligation. She was only semi-conscious and would have agreed with her husband on the ligation as her pregnancy was difficult. However, she could not understand why the doctors decided to perform tubal ligation based solely on her husband's consent. Despite having no regrets, she still felt a little short-changed about the way the decision was made. These two cases highlight the issue of full and informed consent by women in matters of fertility regulation.

**Hospital bed allocation**

Despite hospital expansion, bed facilities in the wards are inadequate. The new obstetrics ward has 115 beds while the gynaecology ward has 43 beds. The wards are always full and it is not unusual to see three women and their babies sharing two beds.

**Emotional and other support given by providers**

While many women recounted experiences about the arrogance and insensitive ways of some doctors, others gave positive statements about them. Doctors were commended for their competence, understanding, support and willingness to listen and answer queries. Following are some of the respondents' statements:

*Despite their negative attitudes, I would still recommend this hospital to others because it is very cheap and some doctors are nice (‘maayo moulog-ulog, ganahan na lang ko’). They have the facilities and experts.*

*I had a nice and comfortable stay here. The doctors were very nice (‘buotan’). At first, I refused blood transfusion but the doctor explained to me that I needed it because I had been bleeding.*

*Before she did curettage, she told me to pray. She said that everything would be fine and that they would take care of me so there is nothing*
that I should worry about. I was really touched with her words of comfort. I cried knowing that I would be in good hands.

Because she knew I am single, she was very careful in doing the internal examination. She said, “Do not be ashamed, we are both women. This will be a little uncomfortable but very quick. Just relax”.

Quality of Care

This section explores the quality of health services in terms of interpersonal relations, extent of family planning services available, security and safety and clients’ satisfaction.

Interpersonal relations

Although acknowledged as potentially risky, pregnancy and delivery are considered natural and normal for women. However, women are also at their most vulnerable during this time: almost all women who delivered at the hospital recounted disempowering experiences at the hands of service providers. Clearly, health providers wield enormous power over clients. Women often hesitated to express their feelings and complaints to health providers for fear of rejection or being given rude treatment. While this is not to say that all caregivers were rude, it was enough to discourage many women from complaining and asking. Word easily spreads among women in the wards about which doctors are easy to deal with and which ones are observed to be rude. For the client unfortunate enough to be assigned to an uncaring or rude health caregiver, it took a lot of courage to voice their concerns, complaints and questions.

Women also attempt to learn from past experiences and try to manage their time at the maternity ward better. However not all experiences are the same and women often get conflicting instructions and end up confused. The experience of this 23-year old urban mother of two children, mirrors the experiences of other women interviewed:

During my first pregnancy, I was asked to go home until it was almost delivery time. So during my second pregnancy, I stayed home until the contractions were intense. However, I was scolded for coming in so late! I was really shocked at their attitude because I thought I was doing them a favour by not wasting their time. I told them I did not want to burden them unnecessarily if it was not time yet to deliver. I received more scolding as I continued to explain my side. I was at their mercy. I was afraid they might make things more difficult for me, so in the end I just kept quiet. My husband was also fuming mad but I told him to keep quiet too. Who would not be confused with their system? If you come early, they ask you to go home. If you come later, they blame you for failing to come early. How would a woman know when is the best time to go to the emergency room?

There were also complaints regarding the poor and impersonal treatment meted out by staff during labour and delivery. Two women shared the accounts of their experiences:

I felt like I was a pig in a slaughterhouse where women fall in line for every procedure. We wait in line for the interview at the front desk, medical history by the doctor, internal examination (IE) and other procedures. At the IE room of the ER, everything is rushed and the doctor is insensitive. “Why don’t you spread your legs wider?… move fast, because there are still others waiting… okay you’re done, next!” The procedure is painful, but their rude treatment is even more painful. I don’t want to be treated like this. Upon sharing this with the other women at the ward, they told me I was unlucky because there were too many admissions for deliveries that day and that my doctor is really noted for being nasty. She even scolded my husband for not having all the medicines I needed. She asked him, “Patyon nimo imong pasyente diri?” (You want the patient to die here?)

They should understand that labour pains can be very painful. So I shouted every time I could not bear the pain. Women are not the same, some women can bear the pain but some cannot. The doctors covered my mouth with a diaper cloth. I really felt very bad with this insensitive treatment.

Women felt they were at the mercy of doctors. They were not allowed to argue and forced to be passive recipients. Differences in social backgrounds
often contributed to the communication gap and this is most evident in the case of poor women. In some instances, physicians think women are incapable of dealing with health problems and blame them for lax health seeking-behaviour. However, blaming clients for the delay is simplistic. Factors including distance, inadequate referral system, cost, perceived stage of the illness or health problems and decision making in the family system influence health seeking behaviour. Socio-economic issues affecting women's health such as conditions of poverty, domestic violence and multiple work burdens have to be addressed by the health system.

**Extent of family planning services**

Most of the women interviewed had not received family planning information and counselling from health providers. While most clients were cautioned about not getting pregnant soon, they received no information about family planning methods. Two women who had induced abortion claimed they were not advised at all about family planning. Only a few were told to visit the outpatient department or health centre for family planning information and services.

During the focus group discussion with health providers, doctors said they gave informal advice on family planning to women during labour and delivery but that this was not enough. Family planning is of concern to women who want to either space births or stop pregnancies and many of them expressed a desire to use contraceptives. Misconceptions about preventing pregnancy by such methods as squatting after sex as well as issues like spousal objection to certain methods were also mentioned. One woman recounted her experience with family planning services:

> My first choice in terms of method was ligation but the doctor said I was too young for this irreversible method. I told her my second choice was the IUD. She simply told me that I could go to the nearest health centre in our barangay for IUD insertion. She did not mention the advantages and disadvantages of the method nor did she mention other methods available at the hospital or the health centre. I told the doctor that I want to have a tubal ligation. She declined saying that I was too young and that I might regret it in the future especially as all of my kids are girls. And yet she did not even give me information about other family planning methods, not even pills.

A few of the women admitted their pregnancies were accidental or unplanned. Failure of the health providers to provide information and services on family planning to these women before their discharge seems like a lost opportunity for controlling fertility. Clearly, reports by women indicate a lack of family planning information and services given to clients.

**Security and safety**

In the focus group discussions, two women shared incidents concerning security in the ward. The obstetrics ward is one big room with 115 beds. Two women recounted that during their stay, two mentally-ill women were placed in the same ward after delivery. One of them locked a client in the toilet and the other pointed a knife at another client. In the commotion that followed, some of the clients ran for safety carrying their dextrose bottles and blood. Everyone was frightened and nervous until the guard secured the mentally-ill patients to their beds in an isolated room. During a visit by the researcher to the same ward, a client slipped on the toilet floor and bled, raising questions on maintenance of order and cleanliness to ensure client safety.

**Clients’ satisfaction**

Women were asked the following questions to determine satisfaction with services:

> “Overall, would you say you were satisfied with the services you received in the hospital?”
> “What did you like best with your stay in the hospital?”
> “What did you dislike most?”

Most of the women cited negative and unpleasant experiences with the care and services received at the hospital. When they were asked if they would return for their next pregnancy or operation, many of them said they would not if they could afford other services. Others stated, “We have no choice, do we have any other option?” Clearly, the need for quick and efficient health management overrides the need to maintain quality interactions in the case of poor women. However, a few of the women did appreciate the quality of care they received in terms of doctors’ competence and kindness.
Perceptions of Doctors and other Service Providers

This section offers insights into health providers’ perceptions and experiences.

**Workload**

The resident doctors are rotated in teams, usually three to four in a team. They go on 24-hour duty every four days, or twice a week, from 7:00 a.m. to 8:00 a.m. of the next day. They make their rounds to all the clients in the obstetrics and gynaecology wards and the Intensive Care Unit accompanied by interns and occasionally, consultants. On an average, each doctor attends to 30 to 40 clients a day for normal delivery, caesarean section, dilation and curettage and other operations such as hysterectomy. The doctors admitted that they could not provide more time for each client because of the heavy workload. On a 24-hour duty, the doctors work almost non-stop. At night, more women come in for deliveries (both vaginal and abdominal) and curettage. The doctors observed that there are more deliveries early mornings than at any other time of the day. At any one time, three resident doctors are assigned to the obstetrics and gynaecology department assisted by clerks (fourth year medical students) and interns to check the progress of labour and monitor infants. They are in the delivery room most of the time after the morning rounds and case conferences. On an average, one hour is spent for checking the progress of labour and assisting the women in bearing down and waiting for supplies to arrive. The doctors attend to many women at the same time and have barely enough time to eat and rest. They also do not go off duty after they serve the required 24-hour duty as there may be other clients needing attention. Resident doctors are also rotated for assignment at the Outpatient Department (OPD) every four days where they serve from 9:00 a.m. to 4:00 p.m. Then they are on call if needed at the Emergency Room. The doctors attend to more clients at the Outpatient Department.

Aside from the challenging workload, doctors have to cope with other problems including lack of supplies, inadequate equipment, shortage of staff and difficult clients. Some doctors have been threatened with physical harm or verbal abuse when they cannot produce supplies for clients. These health providers work in a system where only a small portion of the national budget is allocated to health. The 1999 budget only allocated 2.3 per cent of government spending on health. As a consequence of the Asian economic crisis, budgets of government agencies including hospitals were further reduced. Doctors were frustrated with the system where they have very little decision-making power or control over budgets and work situations.

During the focus group discussion, doctors admitted they normally start fresh in the morning but by the early hours of the next morning, they would be so stressed out they would not be able to tolerate especially the difficult patients (‘init na ang ulo’). Following are some of their grievances:

In the first few hours of a doctor’s duty, she starts with a smile. As the day goes on, the patients never stop coming. In the delivery room, those who are in labour are noisy due to unbearable pain. Then there are patients who come without money for medicine and other supplies. After lunch, this is when some of the doctors start getting stressed and lose their patience. They start getting angry with the patients and watchers.

We are ‘institutionally abused’ and not given proper working conditions, too many patients per doctor, inadequate facilities and support staff. We work here like ‘chimay’ (servant). We push the stretcher and try to secure the medicines and blood supplies, while the husband just looks on and says, “Please take care of my wife doctor, we have no money”. Due to a heavy workload, we have limited time for patients. I really feel guilty. I know I could give better quality service if I were not burdened with so much work. The patient–medical staff ratio is high but doctors are committed. It’s only that there are things and cases that have to be privatised. The frustrating part is that this kind of service is not what the patients deserve. The administration is sensitive to the needs of the hospital. We understand however that there are limitations because it is centralised and the resources and budget are divided between different departments.

In any typical day, a senior resident handles 40 deliveries, does ten surgeries and the rest of the time is taken up by internal
examinations, evaluation of wards and interns, ward rounds and follow-up of patients in other departments. When on duty at the outpatient department, a doctor sees 70 to 100 patients a day hence we can’t really give quality service. We work better under pressure; once you stabilise the mother and the baby, everything is okay. Patient’s education is important to avoid complications. Some patients however are just looking for people to talk to. Doctors should know how to size-up a patient who needs emotional support more than medical interventions.

Doctors’ work is not like paper work. You just can’t set aside cases. If you lose it now, you lose it forever.

Unlike the doctors, a nurse is on duty only eight hours a day. There is paper work to do plus attending to medication of patients in the ward. The nurses are more compassionate probably due to their eight hours regular duty which does not stretch their limits. The doctors on the other hand are hot-headed (‘mainit ang ulo’).

Contrary to the last statement, nurses are just as burdened, with only three nurses attending to 200 women at the obstetrics and gynaecology ward. Carers are often asked to do some of the work of nurses like removing secretion with a suction machine.

Perceived characteristics of clients
If women have experiences to share regarding positive and negative treatments by doctors, the doctors also have their own versions regarding the clients they have to deal with. When asked to describe clients who are perceived to be difficult, these are some of the doctors’ responses:

Those from the city are difficult. They don’t want to pay any single centavo, even when they can afford it.

There are rude patients who don’t even appreciate our efforts. They justify this by saying, “This is a government hospital. We’re the ones paying you from our taxes”.

Patients who know somebody from the hospital or are relatives of hospital employees expect everything to be free. They are also quite demanding.

The single mothers have no watchers’. They don’t bother to come back for follow-up care or check-up. Young, single mothers are also very emotional.

The older patient who has many children and relatives is very difficult. You have to explain to each one of them and they disagree or interfere in the management of the patient’s illness. We cannot afford this, especially as we don’t have all the time to talk to all of them. Time is gold.

The abortion patients are difficult to deal with. They don’t readily admit (to inducing the abortion) and they hide their identity. But we know they did it because they are very pale and there are other indications. Some are high school students.

It is difficult to handle women who have never been hospitalised. They are shocked at the lack of personal care and privacy, very unlike what they find at home or in private hospitals.

There are watchers who expect the nurse to stay with them all the time. They are very demanding.

There are patients who want us to treat them as private patients. They want full attention when they come here.

There are patients who are ‘maarte’ (demanding). They move a lot on the delivery table, which is really high. I tell them they might fall but some just refused to listen. Sometimes there’s no use talking to the patient. I shout at them when they become unreasonable.

There are patients who shout really loud because of the pain. We explain to them that they should not lose their energy by shouting
because they need to bear down. Some doctors would give patients a diaper cloth to bite on. When they concentrate on biting the diaper cloth, the delivery room will be quieter.

There are women who had previous caesarean section and therefore they would know that in the next delivery, they will have another caesarean section especially if they went for prenatal sessions. But they come here with nothing, no money and fully dilated at that. Pregnancy is not an emergency; it is a responsibility. They have nine months to prepare. They think that it’s a government hospital, everything is free.

There are patients who don’t want to take their medicines and yet they also don’t want to go home.

Women who come in at advanced stages of illness, like cancer, are also labelled as difficult. Many of them resort to traditional healers and remedies before seeking medical care. Doctors also complained about rural women’s belief in superstitions largely influenced by elders in the community, which also causes delays in medical intervention.

There are patients who wait for 15 days before they take a bath. We tell patients here to take a bath but they don’t budge because this is against their mother’s advice. Then they apply snake oil all over their body. They smell really bad.

Some women come in very advanced stages. The gap between their first and next visit is wide maybe because they don’t have money for medication. In between they go to the ‘hilot’ (traditional midwife) or ‘arbularyo’ (traditional healer). When this fails, they come back to us. This is very frustrating as we could have done something earlier. Treating illnesses in advanced stages is very expensive for the hospital.

On the other hand, hospital staff are often frustrated when women come to the emergency room in a critical condition during pregnancy or delivery. When this happens, the already overworked physicians have to work even harder to negotiate for medicines and blood. The doctors also have to schedule clients for emergency surgeries and there are times when they cannot enter the operating room because there are already several ongoing surgeries.

Adequacy of supplies and facilities
The obstetrics ward does not have enough beds. Often a client will share the bed with another woman together with their babies. The supply of medicine is another problem reported by the doctors, which also confirms the complaint of clients regarding unavailability of medicine and supplies. Doctors complained that clients and watchers did not keep the toilets and ward clean. They did not dispose napkins properly and leftover food is often dumped in the sink or toilet bowls clogging the drainage pipes. After a flooding incident at the ward, the hospital staff put up posters reminding clients and watchers to observe proper use of the toilet and sink facilities.

Family planning
One doctor admitted she believes more in natural family planning methods and recommends the rhythm method to women. She said she would only recommend tubal ligation if the woman is underweight and has spousal consent. Another doctor finds the rhythm and withdrawal methods ineffective, and condom least of all and it is the least used among all the methods. She said she would normally recommend IUD and oral pills if the woman is over 38 years. She rarely recommends ligation, except in cases where the husband has given consent. Her other considerations for ligation aside from age, are parity and number of children. Another doctor has differing views:

I recommend ligation only if the couple has four children. What if something happens to the husband? I recommend more temporary methods like pills because this method is quite accessible to women. I least recommend IUD because it causes infection.

Induced abortion and post abortion care
A large number of the women in the in-depth interviews had experienced at least one unplanned or accidental pregnancy. Except for two who had induced abortion, others carried the pregnancies to full term. In most cases the women
were not using any family planning methods. A few of those who got pregnant accidentally were practising the withdrawal and the rhythm methods. Non-use of any method was due to the fear of side effects. None of the spouses used condoms or underwent vasectomy. The use of mainly female methods of fertility control illustrates the overwhelming responsibility of women in fertility control.

All service providers expressed disapproval of induced abortion, which explains their negative and judgmental attitudes towards women who had undergone abortion. Most doctors found it difficult to draw an admission from the women who had induced the abortion, despite using words for encouragement. Failing that, the doctors would threaten the women by citing serious cases of women who died because they did not tell the truth and consequently did not get proper treatment. A doctor confided:

_I can’t understand why women resort to abortion. There are people who want a baby and yet there are women who have no qualms about having abortion. And when a woman comes here, the watcher has no money. So we end up doing everything - looking for dextrose, needles and blood. Some doctors get angry and shout at the woman in front of the other patients. We have many facilities in family planning and yet they resort to abortion._

Doctors are of the view that about half of those admitted for abortion complications are single women, mostly street children. They also emphasised the criminal aspect of abortion and expressed their frustration of being a part of it. One doctor said:

_It’s very disappointing, very sad for us. We end up as accomplices because it is as if we finish the job after the catheter. We sound like a broken record scolding those who are habitual abortees. They deserve the pain during dilation and curettage procedure to give them a lesson for what they did (‘para morag gaba sa ilang gibuhat’). I would want to discuss it with their watcher, relatives or parents so they will be put to shame for what they did. Maybe they did it because of poverty, or because they have too many children or it was accidental. But this does not justify having abortion. This makes me really angry (‘makalagot’)._  

While it is obvious the doctors quoted are judgmental about the women who resort to induced abortions, no criticism or judgement is made of the male partners and their role in the pregnancy. It makes one wonder if the health care givers also place the burden of fertility control on the women.

**Training curriculum for health providers**

Most of the doctors find the theoretical and technical component of the medical curriculum adequate as borne out by the many graduates of the residency-training programme who have passed the National Board Certifying Examinations. They admitted however that their curriculum lacks the socio-cultural and emotional aspects of care. They suggested that to be more tolerant and understanding of their clients’ conditions, the socio-cultural context should be given more emphasis.

The doctors likewise admitted that their medical school training did not teach them sensitivity to the social conditions of their clients. Traditionally, medical school training teaches students to look at clients as mere clinical cases. This lack of awareness of socio-economic and cultural context of their clients lives, compounded by very heavy workloads, explains the negative attitude and insensitive treatment meted to clients. The doctors’ lack of knowledge of the socio-economic context of women and their families are reflected in the anger and impatience when poor clients and their family cannot produce medicines and supplies needed and when clients adhere to supernatural health beliefs and practices.

The doctors further cited the big class size that a teaching doctor had to handle which could have contributed to the decreasing proportion of students who pass the medical board exam. The passing rate of the medical school is deteriorating. This is because the class size is so big, as many as 80 to 90 students per class. Some students fall asleep. Learning is not effective because teachers cannot get their full attention. The students just borrow visual aids of the teachers. The third year level extension work is very important because this is application of the theories they learned in the first two years.
One obstacle in effective treatment is the service providers’ lack of awareness of gender relations and dynamics. As evidenced by the women’s comments, women cannot independently decide on spacing births or limiting family size because of spousal objections. Furthermore, lack of husbands’ support negates doctors’ advice to women about rest, reduction of workload and special diets. The study findings revealed that most doctors had not had training on gender-sensitivity. A few however had attended talks on violence against women. Doctors therefore demonstrated inadequate understanding of gender issues. Nurses on the other hand, had attended training on gender-sensitivity and violence against women. They claimed to now have a better understanding of women’s realities and suggested training on gender issues for all staff particularly the surgeons. Most surgeons are males and are not sensitive to women’s needs.

Other Sources of Support to Women Users

Most women received support from husbands who were mainly responsible for transporting them from their residence despite the distance and the difficult terrain. Husbands took responsibility for arranging funds to cover expenses, follow-up billing, negotiate with the social worker for discounts, get clearance for discharge, buy or secure the necessary medicine and supplies such as blood, drugs, syringe and intravenous solution. Women mostly had family and relatives attending to them while in the hospital. Those who delivered had husbands staying with them most of the time.

Some women who wanted tubal ligation reported that their husbands were against this permanent method and spousal consent was difficult to get in cases where circumstances made them desire either a boy or a girl. This raises questions on why family planning is not discussed extensively with couples after childbirth.

Some Ethical Concerns

Regarding quality care and gender-sensitivity, the researchers noted that the delivery room lacked privacy. Apart from doctors, nurse and midwife, others, including medical students, cleaning staff (female) and nursing aides (male and female) also have access to the room. The lack of privacy compromised women’s modesty. Doctors also felt uncomfortable about such a huge delivery room with women’s genitalia in full view of those present, including other clients.

A service provider was asked how a news reporter managed to enter the ward to interview a woman admitted for abortion. The case was sensationalised by the media and the poor woman was shocked to know that her case was in the local papers. A police officer was at the ward to detain the woman upon her discharge from the hospital. Upon inquiry, the researcher was informed that it was the guard who allowed entry of the reporter without the consent of the client.

FINDINGS

Women’s Experiences in the Hospital

Most of the women admitted for obstetrics care came for childbirth, either normal delivery or caesarean section. The rest came in for spontaneous and induced abortion. Other gynaecological interventions included ovarian cystectomy and hysterectomy. The following reasons were cited for choosing the hospital: free or low-cost services; adequate facilities and equipment; referral by friends and other hospital; and access to specialists and experts.

Many women experienced unreasonably long waiting times before receiving care. Although clients pay a minimal amount for the hospital stay, they incurred expenses for medicines and supplies. Doctors reprimanded clients or watchers for not providing the necessary medical supplies. Clients who came from remote areas had to endure long journeys and incur travelling expenses. Often, they had to contend with ill-equipped health centres and be referred to a tertiary hospital for admission. Consequently women were in a weakened condition or unconscious state when they reached the hospital. Hospital staff were often frustrated when women came to the emergency room late in their illness or pregnancy.
A large number of women who delivered at the hospital spoke of rude, insensitive and unsympathetic nurses and doctors. They also complained about service providers’ impersonal treatment. It was observed that during rounds, doctors talked directly to husbands and not to women clients. To an extent, doctors clearly did not respect the women clients’ rights when they performed ligation based only on the husbands’ consent. However, there are competent and helpful doctors who demonstrated their genuine concerns for the clients’ health, as pointed out by some women in the study. Most women admitted for childbirth and abortion left the hospital without adequate discussion of their reproductive health needs like family planning.

Perspectives of Doctors and Other Service Providers

Doctors identified obstacles to their work including heavy workload, shortage of nurses and auxiliaries (nurse’s aide), inadequate supplies and equipment and lack of budget. They also cited the limitation of medical curriculum which did not cover the socio-economic and cultural context of clients’ lives.

Resident doctors had a heavy workload and were on duty 24 hours every four days or twice a week. They were burdened with too many patients in a day with various obstetrics and gynaecology needs. After the 24 hour-duty, they stayed on for case conferences and attended to matters they were not able to perform during their duty. They often had irregular meal times. Similarly, nurses were as burdened with only three nurses at the obstetrics and gynaecology ward attending to 200 clients in an eight-hour shift daily.

Besides the heavy workload, doctors had to deal with difficult and demanding clients, which often tested their own patience. They were also disgusted with women who resorted to abortion despite the availability of family planning information and services. The experiences of women with doctors in terms of their negative and positive attitudes ranged from blaming and scolding to lapses in observing medical confidentiality which led to exposing one woman to the media and to criminal prosecution with possible punishment.

There are hospital regulations that act as barriers and affect women’s access to services, namely a husband’s consent is needed before a woman gets ligated.

There is a lack of comprehensive services on sexual health, reproductive tract infections, family planning and post abortion complications. Significantly, doctors expressed interest in training on gender-sensitivity, violence against women, ethics and quality of care.

RECOMMENDATIONS

Based on the above findings, the following recommendations are made for the hospital, non-government organisations, and academia and for future research.

Hospital

- Orientation of hospital administrators and training and re-training of service providers in the hospital on gender issues particularly women’s health, reproductive health and rights, violence against women, sexuality, ethics and quality of care.
- Allocate additional resources for more resident doctors, nurses, nurse aide and janitors; essential drugs and other medical supplies; bedding and beds; and preventive service like family planning and health education.
- Training health providers to build knowledge, attitudes and skills for provision of women-centred family planning services including management of abortion complications.
- Health providers, women activists and researchers could develop a protocol to include questions exploring issues of violence, reproductive tract infections and family planning.
- Family planning to be integrated with other services like health education through information, education and communication (IEC) materials that can be posted or distributed at the obstetrics ward.
• Health providers to engage in unbiased and forthright discussion with women clients of the available methods of fertility regulation, to safeguard women's right to information and informed choice.

Non-Governmental Organisations and Academia

• Conduct more workshops at community level to address violence against women, sexual health, women's rights and other related issues.

• Advocate for women's representation in hospital policy, for example, women's representation on the hospital ethics committee.

• Lobby for allocation and implementation of the nationally-mandated five per cent GAD budget by the hospital.

• Build capacity of health providers to do health and gender research.

• Advocate to the Commission on Higher Education on the need to integrate issues of gender, women's health, violence against women, men's responsibility, ethics, quality of care and sexuality in curriculum of medical schools and other health institutions (midwifery and nursing) and college programmes.

Further Research and Research-related Activities

• The research results could be utilised for policy and advocacy work.

• Future research proposal budgets could allocate more resources for a participatory research process, advocacy and other activities.

• Researches on gender and reproductive health should involve all stakeholders (women, non-governmental organisations, academia and government) throughout the whole research process, including the planning and action phases.

• Similar research in another government hospital should be conducted to include other departments, not just the obstetrics and gynaecology department.

• Conduct research on the impact of health sector reforms (for example, semi-privatisation of hospitals) on the quality of care accessed by women.

• Conduct more research on the decision-making process of women who had tubal ligation with a focus on cases similar to the experiences of those women in this study.

ACTIVITIES AND OUTCOMES

As part of its action component, the following activities were conducted by the researchers:

• Dissemination of the findings to the hospital service providers of the obstetrics and gynaecology department including the chief of the hospital, interns and medical students.

• Findings from the research were incorporated into training sessions on gender-sensitive health care and ethics, quality of care for health providers at the hospital.

Actions of the hospital and doctors as an outcome of the research were:

• Hospital management has installed a suggestion box for clients for the first time to elicit comments, complaints and suggestions.

• More curtains were added in the emergency room to improve privacy.

• The establishment of an area for watchers and a birthing centre at the hospital.

• The protocol (history-taking form) used in the emergency room and the Women and Children Protection Unit now includes questions on violence against women and sexuality concerns.

• More visible participation of doctors in advocacy and capacity-building on issues related to women's health.
REFERENCES


NOTES

1 A watcher is a person either family or friend who helps to take care of people hospitalised.
Assessment of health needs and services for women workers in a Sri Lankan Free Trade Zone

Kamini Alahakone, Ranjit de Alwis, Thana Sanmugam and Varuni Sumathiratne

INTRODUCTION

This study examines the provision of health services for women workers in a Free Trade Zone (FTZ) in Sri Lanka and assesses the services for gender-sensitivity and quality of care. Of the few studies conducted in FTZs, few have addressed the health needs of women workers. Therefore the research was women-focused and attempted to capture health needs as perceived by the women. At another level, the study sought to be action-oriented and effect change in managements’ and health providers’ attitudes towards health care provision through dialogue and training on gender and health issues based on the findings. Given the action-oriented approach of the study, raising awareness on gender-sensitivity among service providers, employers and workers became a priority. To this end, capacity-building programmes on medical, psychological and occupational health-related issues relevant to FTZ workers were conducted to effect changes that would improve the health and wellbeing of FTZ women workers. By disseminating the research findings to the relevant authorities and making recommendations to improve the quality of health care available to women workers, the study hopes to influence policy outcomes.

One of the weaknesses in government’s approach to women’s health has been the exclusive focus on maternal health resulting in neglect in areas such as occupational health of women workers, adolescent health and health care for pre-menopausal and menopausal women. Given the women-centred and occupational health focus of the study, the following questions were raised:

• What are the health problems of women workers as expressed by them?
• Do women have adequate access to health care they need and want, and what are the barriers that impede access?
What are the attitudes of health care providers towards women’s needs, access and barriers with regards to women’s health?

This study aims to identify health problems as expressed by women workers in the FTZ and assess the quality of gender sensitive-health care available to them. It then sought to bring about change as an immediate outcome of the research process by initiating capacity-building exercises for both the women and service providers.

 CONTEXT: SRI LANKA AND THE FREE TRADE ZONES

Organisation of Health Services

Health services at government medical institutions in Sri Lanka are free of charge and cover preventive, curative and rehabilitative care. The private sector provides mainly curative care estimated to be nearly 50 per cent of the out-patient care of the population and services are largely concentrated in the urban and suburban areas. However 95 per cent of inpatient care is provided by the public sector. Ayurvedic and homeopathic systems of medicine are also practised. A health care unit can be found on an average of not less than 1.4 km from any home and free allopathic services are available within 4.8 km of a client’s home. The public health sector comprises a medical officer of health (MOH) or a district director of health services (DDHS), public health nurse, public health inspector and public health midwife in each of the 302 divisional secretary areas. The medical officer of health or district director of health services is responsible for the care of pregnant mothers, infants and children, including school children through a wide network of clinics which provide ante and postnatal care, family planning and child care. The public health midwife covers a population of approximately 3000 and provides domicile care while public health inspectors are responsible for monitoring sanitation, environment, food and hygiene.

Free Trade Zones

The Board of Investment (BOI) established the first Free Trade Zone (FTZ) in 1978 to provide a one-stop export promotion facility for investors. However, the concentration of factories in one location led to large-scale migration of workers; most came from remote areas and were mainly women. The government provided low interest loans for households in the area to improve their residential capacity for boarders. However housing, water and sanitation remained a major problem in most FTZs. Infrastructure problems such as poor roads and inadequate health facilities in factories, contributed to social problems including violence against women. Although in principle all national labour laws apply to factories in the zone, enforcement is not easy and workers do not have the right to unionise. While there are workers’ councils, these are not effective. Eighty per cent of the workers are women and the percentage of women at supervisory level is also high. However, nearly 70 per cent in the administrative grades are males (Economic Review, July 1994). An NGO report suggests that more than 50 per cent of FTZ workers are in the garment industry (Dabindu Collective, 1997). The same report states that 28 per cent of female workers in Koggala were fined or punished for not reaching their targets, indicating that pressure is exerted on the workforce to raise productivity. In most cases the women were behind target and made to meet the target after working hours without any extra payment.

Garment workers are exposed to repetitive upper limb movement, stress, awkward postures and local vibrations leading to work-related muscular skeletal disorders. Many of them also report reproductive and sexual health problems. A survey of FTZ workers’ knowledge and attitude towards family planning and sexual health revealed that 90 per cent of married and 85 per cent of single women were aware of contraceptive methods (FPA Sri Lanka, undated). A study by the Alcohol and Drug Information Centre (ADIC) on negotiations for safe sex by FTZ workers showed that women did not respond to questions on HIV and STDs. There was a high percentage of ‘do not know’ to questions on HIV transmission despite participation in HIV/AIDS awareness/prevention programmes.

The Selected FTZ

The selected Free Trade Zone, situated 132 kilometres from Colombo has 13 factories of which ten manufacture garments. The total workforce comprises 24,368 women and 742 men workers. Health services are available in and around the research site. All factories provide free breakfast in addition to mid-morning
and afternoon tea. One factory also provides free lunch. A number of NGOs provide a variety of services and facilities including reading material, games and sports, and training programmes such as sewing, cake making, bridal dressing, beauty treatment and flower arrangement.

While provision of health services in factories is not a legal requirement, first aid facilities are mandatory. Most factories had first aid centres and offered the services of a full-time first aid nurse. One factory had a medical centre with a doctor visiting twice a week. These facilities do not offer reproductive and preventive health services. Reproductive health services are provided by the medical officer of health or district director of health services, who operates a network of clinics for ante and post-natal care, family planning services as well as immunisation and child health. Nutritional supplements are available for pregnant and lactating mothers and underweight children. Public health midwives provide domicile care for mothers and infants. They also provide family planning counselling and distribute oral contraceptives and condoms at subsidised rates. Each public health midwife caters to about 3,000 people.

There are two government hospitals situated within two to five kilometres from the zone. Each of these hospitals has two doctors and two midwives. There are no nurses. Access even to the closest hospital is difficult because of inadequate public transport. The occupational health centre specifically set up for FTZ workers is under-utilised and now caters to the general community. The centre has four medical officers and basic laboratory facilities. Facilities are also available for a woman doctor to attend to women clients. Services are provided free of charge. A teaching hospital with free specialist facilities is situated 16 km away. Needless to say many private practitioners have facilities outside the zone. Counselling services are available through the Women’s Bureau Centre. Given that government health facilities are open to the public only during working hours from 8:00 a.m. to 5:00 p.m., access to working women is limited.

RESEARCH METHODOLOGY

Being a participatory action-oriented research, data was mainly collected through questionnaires and interviews. A series of workshops were held for all stakeholders and the outcomes of discussions held with management of factories whose workers were part of the study, were analysed. The workshops with administrators and the Board of Investment officials on the preliminary findings increased the credibility of the research and enabled access to factories for interviews and observations. Other methods included informal discussions and visiting specialists to gather specific information.

As the FTZ restricts entry, the Board of Investment’s approval had to be obtained for the study and accordingly a letter was sent to the Task Force on Safety and Welfare of FTZ women workers. After initial discussions and meetings, CENWOR was given permission to proceed with the research in 1999. The team comprised the principal researcher, a research assistant, Deputy Commissioner of Labour (occupational health) and a coordinator from CENWOR and was responsible for monitoring the study, advising on issues and finalising questionnaires. The local steering committee comprised the provincial director of health services, the deputy, department officials and a doctor in private practice who attends to FTZ workers. Most of the steering committee members were women and advised on local issues, assisting the research team and implementing relevant recommendations. Women workers could not be represented as the management was unlikely to release them for meetings. While the Board of Investment declined to be on the committee, its officials’ suggested that a meeting with factory managers to brief them about the research and preliminary findings, proved to be beneficial as it created a better understanding with the factory management and dispelled fears that the study findings could be used against them. This enabled the researchers to conduct interviews and provided access to medical centres within the factories.

DATA COLLECTION

Workers

The two methods adopted for collecting data from workers were self-administered questionnaire and interviewer-filled questionnaire. The latter was used to validate the findings of the self-administered questionnaire. The self-administered questionnaire was designed by the research team, translated into
Sinhala (local language) and field-tested. Based on the results of the pilot study the questionnaire was amended.

Given the delay in getting permission for the research, the steering committee suggested that field midwives distribute the questionnaires to FTZ workers at their homes and boarding houses and collect them after completion. Therefore it was not possible to randomly select individuals. However, five areas surrounding the FTZ were selected randomly. Each of the five midwives was given 100 questionnaires for distribution. Four hundred and thirty one questionnaires out of the 500 distributed were eventually collected. All 13 factories were represented in the sample.

Interviews via the interviewer-filled questionnaire were held with 52 workers from seven factories chosen at random. It was not possible to get a sub-sample from the sample of women who filled the self-administered questionnaire, as respondents could not be traced given that names were not identified. The interviews offered more responses and information and also validated the findings of the self-administered questionnaire. The research team and a senior retired public health nursing sister conducted the hour-long interviews. The factory management provided facilities for the interviews and released workers during working hours.

**Health providers**

Data from health providers were obtained through questionnaires and workshops. Two questionnaires were designed for doctors and nurses. The nurse’s questionnaire was translated into Sinhala before distribution. These questionnaires included interviewee profile, needs, awareness and suggestions for improving services.

Four workshops were held for doctors, nurses, supervisors and management to discuss the preliminary findings and assist them to be more sensitive to the needs and problems of women workers. At the workshop for doctors, discussions on psychosocial problems and occupational health hazards led to the demonstration of stress management techniques. The counselling centre informed participants about their services to better facilitate referrals.

Initial discussions with nurses revealed that some of the workers were not satisfied with factory medical centres services. Therefore a workshop was conducted to enable nurses to provide more effective care for stress related complaints including headache, backache and tiredness. Unfortunately only nine nurses out of 20 were released to attend the three-hour programme. The workshop identified problems faced by the nurses and those that had not been asked in the questionnaire. A second workshop for nurses introduced issues from the manual entitled “Health Workers for Change”. Twelve nurses attended this workshop.

At the workshop for supervisors, an important preliminary finding presented was that some of the health problems expressed by workers were due to supervisors’ not respecting the dignity of women workers. A clinical psychologist facilitated the discussions, and problems of the supervisors were also taken up.

At the workshop for managerial staff, the findings from 100 questionnaires randomly selected from the 431 completed questionnaires were presented. Besides facilitating close contact between the managers and the research team, the factory management met the provincial director of health services and discussions were initiated on women’s health problems. An immediate outcome of the workshop was the decision that priority would be given to FTZ workers seeking care at the occupational health centre. In addition emergency service hours were extended until 6:00 p.m. enabling workers better access to services.

Informal discussions were held with all the Board of Investment officials, service providers, women workers, supervisors and management. These discussions provided more information on service problems, identified ways to improve services to meet the needs of workers and raised awareness about gender-sensitivity in health care.

**Facilities**

A checklist was used to determine the availability of the facilities and observations were made at the two government health service outlets and three factory medical centres.
Sample Size

<table>
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<tr>
<th>Method</th>
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<tbody>
<tr>
<td>Self-administered questionnaire</td>
<td>431 women factory workers</td>
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<tr>
<td>Interviews</td>
<td>2 women factory workers</td>
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<tr>
<td>Health providers</td>
<td>9 nurses; 6 doctors</td>
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<tr>
<td>Number of facilities outlets; three factory medical centres</td>
<td>5</td>
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Except for the self-administered questionnaire and interviews, all other questionnaires were hand tabulated by the research team. Statistical analysis was done at CENWOR. Confidentiality was ensured by not having to state respondents’ names in the questionnaire. The purpose of the research was included in a preamble to the questionnaire and respondents were not compelled to fill in the questionnaire or answer some questions if they did not wish to do so.

LIMITATIONS

Given the delay in getting the Board of Investment’s approval for entering factories, a random sample for distribution of questionnaires was not possible. In addition, the sub-sample for interviews was not from the main sample. Although a doctors’ strike delayed communication with midwives, they were still able to distribute 500 questionnaires, out of which 431 were completed. One of the reasons for non-collection was that the workers were too tired to fill up the questionnaires after returning late from work. However this factor did not significantly influence the research validity because the findings from the 431 questionnaires tallied with the 52 who were interviewed.

Another gap was the poor response by some workers to sensitive issues in the self-administered questionnaire. Conducting interviews within the factory premises may have resulted in biased answers and it was not possible to select a random sample for interviews as the study required management to release workers without interrupting production. This limitation may not have had any effect on the results since findings of both samples were similar to a great extent. It was not possible to have focus group discussions as planned due to lack of time and difficulty in organising them. Some factories were reluctant to release supervisory and nursing staff to attend workshops as it would affect production. Response from some factories to attend the workshop for managers was poor. It was also not possible to obtain the desired worker participation for workshops and representation on the local steering committee. There was no in-depth analysis of reproductive health, rights and empowerment of women and violence against women, particularly sexual harassment at the work place. However some of these issues surfaced at interviews and discussions. Gender-sensitive indicators were also not identified in this study.

FINDINGS

<table>
<thead>
<tr>
<th>Table 1: Key Data from Questionnaires</th>
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<td>Profile of women in self-administered and interviewer-filled questionnaire samples</td>
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<td>Not reported</td>
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Chapter 6: Sri Lanka
Both samples showed a preponderance of young women between the ages of 20 and 29 years; 72 per cent and 61 per cent respectively of the self-administered questionnaire sample and interviewer-filled sample, confirming the generally known fact that mostly young women are employed in the FTZ. Ninety-nine per cent of the workers are Buddhists. About 55 to 60 per cent of the women had ‘O’ level qualifications while 11 to 16 per cent had passed ‘A’ Levels, indicating a fairly high level of education in this workforce. Unmarried women accounted for around 75 to 80 per cent of the sample. Of the married women approximately 65 to 70 per cent had one child or no children (65 per cent and 46 per cent in the two samples respectively had one child) and 21 per cent had two children, showing that the married workers had small families. In the larger sample, the percentage of mothers with children less than five years of age was 35 per cent in comparison with 18 per cent among the workers in the interviewer-filled sample. It is possible that the larger sample will be more representative of the situation of mothers. Almost half the spouses of the married women were in salaried employment and about 20 per cent were self-employed. Other than children, the dependents cited in the self-administered questionnaires were either parents or siblings of the workers, reflecting a high representation of unmarried workers in the workforce.

Employment patterns
About 50 per cent of the workers had less than two years of service at their present work place. Around 30 per cent of the workers had two to five years of service. Only around 20 per cent had completed five years of service. This indicates a high turnover of workers. Forty-nine per cent of the self-administered questionnaire sample and 58 per cent of the interviewer-filled questionnaire respondents were machine operators. One nurse was also included in the sample. Nineteen categories of workers were represented in the sample. Although the majority were sewing machine operators, only 31 per cent of the respondents had reported sewing as tasks performed, while 36 per cent had not reported tasks performed.

Health problems
The women’s most frequent complaints were headaches, backaches and menstruation pain, followed by abdominal pains (gastritis) and chest pain. Thirty per cent of the workers mentioned ‘feeling sad’ and ‘feeling tired all the time’. About 12 to 15 per cent did not mention any complaints. Twenty one per cent of the women interviewed and five per cent of the self-administered respondents mentioned problems other than those listed, including urine infection, eyestrain, excessive sweating, pain in limbs, loss of weight and general weakness. Between 20 to 25 per cent of the workers reported having vaginal discharge at the time of the interview. It needs to be mentioned that a high percentage of workers (31 per cent) in the self-administered questionnaires did not respond to this question, indicating reluctance to reveal problems related to sexual health. About 50 to 60 per cent of the workers categorically denied having such complaints prior to employment in the FTZ.

Health-seeking behaviour
Only 20 to 35 per cent of workers reported having used the first aid centre of the factory for treatment. A private clinic close to the zone is popular among the workers. This was confirmed by responses in the self-administered questionnaires. Seeking private treatment was high among workers (50 to 70 per cent). Only 27 per cent of those interviewed and three per cent of the self-administered questionnaire sample reported visits to government hospitals. Six per cent of those interviewed and 15 per cent of the self-administered questionnaire sample had attended the occupational health centre specifically set up for FTZ workers.

Only four per cent of the interviewees had sought treatment from ayurvedic practitioners. However, the questionnaire did not seek why private health services were preferred to free state health services. Factors that might have influenced workers’ decision to seek private care are the unavailability of government health facilities after working hours, long queues to obtain treatment, lack of faith in treatment given and lack of respect shown by staff. Most workers made one to three visits per month to clinics (61 per cent and 42 per cent of the self-administered questionnaire and interviewer-filled samples respectively). Though 90 per cent of the interviewer-filled sample and 67 per cent of the self-administered questionnaire respondents said ‘yes’ to a direct question regarding whether they were satisfied with the medical services, subsequent discussions revealed that they were not fully satisfied. Significantly, one fourth of the interviewees stated that they had to wait over one hour to be attended to at the clinic. Of the 64 in the self-administered questionnaires
who specifically stated that they were not satisfied with the services, only 38 gave reasons for this dissatisfaction. The reasons for their dissatisfaction reflected the ineffectiveness of treatment, non-availability of drugs, inconvenient clinic times, long time spent at these clinics, and their inability to afford treatment at a private facility.

While workers said that the doctor spent two to ten minutes examining them (40 per cent of self-administered questionnaires and 59 per cent of interviewer-filled sample), they also reported that the health problem was explained to them and instructions on how to take medication given. However, very few of them were informed of the name of the medicine. Some 60 to 70 per cent of the workers purchased prescribed drugs. Medicines are given free of charge at government hospitals and factory medical centres, but since a high proportion of workers do not access state health care facilities, they are unable to get free drugs.

**Reproductive health**

Thirteen per cent of the self-administered sample said they knew about reproductive health, 23 per cent had no knowledge and 64 per cent declined to respond to the question. Forty-one out of 57 from the questionnaire respondents and 90 per cent of the interviewees requested for more knowledge on reproductive health. Information on STDs was inadequate as well, with 69 per cent of the self-administered questionnaire sample and 23 per cent of the interviewer-filled sample not being able to name any STD. They were either unaware of it or simply did not wish to respond to the question.

Among the married workers, eleven of the 67 workers in the self-administered sample and two of the 14 workers in the interviewer-filled sample were pregnant. Half of them were in their first pregnancy. Most of the pregnant women in the self-administered questionnaires were visited by the area midwife and attended the antenatal clinic, as were the two pregnant women from the other sample. Workers specifically stated that they could not avail midwife services as they were at work when the midwife visited them. Fifty-six workers (36 per cent) from 11 of the 13 factories stated that they were entitled to three months maternity leave. Their answers were vague in respect of entitlement time for breast-feeding. Only 20 per cent of them specifically mentioned a break of an hour or more for breast-feeding.

**Work-related and other problems**

Surprisingly 60 per cent of the interviewer-filled and 79 per cent of the self-administered questionnaire workers did not report any problems. Only 21 per cent of the self-administered questionnaire workers and 40 per cent of the interviewees reported problems related to the overall work conditions and structure, and less due to daily conditions. Leave-related issues, inadequacy of remuneration and supervisors’ harsh treatment were identified. Workers stated that they were hurt when scolded by supervisors. Discussions held by interviewers revealed that inability to meet work targets was a major problem, yet workers were reluctant to mention it in the questionnaires. Although 86 per cent of those interviewed said they were both physically and emotionally comfortable at the work place, only 40.6 per cent of the self-administered questionnaire sample concurred. This difference could be because the interviews were held at the work place. Suggestions to improve work situation included creating awareness among supervisors, improving facilities and maintaining clean toilets.

Only seven per cent of the workers in the self-administered questionnaire and 35 per cent of the interviewer-filled sample reported family problems. Being away from home and the need to support the family emerged as main concerns. Economic hardships, hostel living problems and not getting jobs that commensurate their qualifications were also mentioned. Some of the perceptions articulated were the ‘best part of my life is wasted’, ‘no affection or friends’ and ‘social problems’. Those with infants and children highlighted the lack of time spent in caring for their children.

**Coping with problems**

Confiding in close friends seems to be the most popular method of coping with problems. According to those interviewed, the best method of coping was discussion with the family while women in the questionnaire sample preferred to engage in joyful activities. Only 35 to 40 per cent were willing to discuss problems in a confidential manner. Of the 173 workers from the self-administered questionnaire sample who wished to discuss problems, only 31
per cent gave suggestions which included corresponding through letters and visits by counsellors. A fairly large proportion suggested time off being given for counselling consultations. However, 39 per cent knew about the counselling centre and only 17 per cent had visited the centre. The main reasons given for not visiting the centre were that they could not obtain leave and many considered counselling unnecessary. Many of the women had not attended any training programmes and were unaware of non-governmental organisations’ education efforts.

**Access to Health Care Services**

**Distance**

There are many health facilities within easy reach of the FTZ workers, in addition to the occupational health centre set up mainly for them. Private medical facilities are also available within close proximity to the zone. Therefore distance is not perceived to be a problem for women workers in accessing health care. Government medical institutions including the occupational health centre and medical centres within factories provide free services. Private medical practitioners charge for their services. Despite this, most workers still prefer to seek treatment from private practitioners in the area.

**Availability of health care providers**

Only one medical centre has a doctor visiting twice a week. Nurses treat minor ailments such as headaches and gastritis. First aid is also provided for minor injuries. Major injuries and illnesses such as chest pain are referred to the government hospitals where qualified medical doctors are available. The researcher observed that there were too many FTZ workers needing medical attention, and the medical centres at the factories are unable to cater to all their health needs. This issue was discussed at the local steering committee meeting and the government agreed to release a doctor once in three months to visit the factories.

**Satisfaction with services**

Although a high percentage of workers said in the questionnaires that they were satisfied with the services available, subsequent discussions with them revealed otherwise. The reasons for dissatisfaction were related to the doctor’s perceived lack of concern, lack of investigations, long waiting time, unavailability and high cost of drugs. Government health services are not popular with workers for these reasons.

**Respect for women’s rights to quality health care**

Discussions with workers during interviews and nurses at workshops revealed that junior staff working in the occupational health centre had no respect for the workers. This was brought to the attention of the officer in charge of the centre who then instructed the staff that priority be given to FTZ workers. This indicates that besides medical and paramedical personnel, junior staff must also be made aware of clients’ rights in health care.

**Comprehensiveness of services**

There are no facilities in the government medical institutions for STDs and cancer screenings, family planning and maternal and child health care. However the latter two services are provided by the medical officer of health or district director of health services through a wide network of clinics in the area. Since most health problems of workers are stress-related in origin, there is a need to create awareness among doctors regarding these problems. For family planning needs, women are counselled by public health midwives or doctors and asked to select contraception from the options offered. Clearly, there is no centre which can meet all the health needs of these women workers.

**Technical competence of service providers**

Although all the doctors in medical institutions providing care had basic medical degrees, their knowledge of stress and occupational health problems was inadequate and limited to medication for relief of symptoms. This limitation was addressed at the workshop for doctors.

**Adequacy of facilities**

The facility checklist of the two government medical institutions visited revealed that basic facilities are available. Equipment, medicine, toilets and privacy for consultations were satisfactory. Except for the medical centre in one factory where a doctor visits, all other factory medical centres however were lacking in drugs and privacy for consultations with the women workers. Except for one factory where the doctor visits and individual health records are maintained,
the other factories do not maintain adequate records. There are no records of treatment given either.

**Gender-sensitivity of health services**

Women doctors were available at both government health facilities visited. The doctor who visits a factory medical centre twice a week is also a woman and all nurses working in the government health facilities as well as factory medical centres are women. The medical officer of health or district director of health services who provides maternal and child health and family planning services is also a woman doctor. But these appointments are coincidental as the scheme of recruitment for these posts do not specify the gender of the medical officer. In the past, there were a few posts in the government sector designated for women medical officer in areas which are predominantly Muslim. In the majority of the factories’ medical centres, women workers were not provided facilities to ensure privacy. Therefore it can be assumed that health service providers are not sensitive to gender issues. In general, husbands’ consent is not required to seek treatment or for the choice of medical facility. However a husband’s written consent is required for tubal ligation.

**Nutritional status of women**

It is generally assumed that women from villages are malnourished because of poverty. Given that FTZ workers are mainly from rural areas and belong to a low-income group and that they lack resources and time to prepare meals, their nutritional intake is inadequate. Most workers bring only rice and one vegetable for lunch and their diet is low in protein but high in phytates contained in leafy vegetables. Both these factors are not conducive to the absorption of iron and the loss of menstrual blood cannot be replaced by this diet. This could lead to anaemia, which may be the cause of workers ‘feeling tired all the time’.

**Mental wellbeing**

While women in the self-administered questionnaires did not identify being scolded by supervisors at work a problem, a few of them stated that it was a problem in the working environment. During the interviews, six workers said that they felt hurt when scolded by the supervisors for not achieving targets. During informal discussions with the workers, it was evident that this was a major problem among them, although they were reluctant to write it in the questionnaires for fear of displeasing the management.

**Findings from Discussions with Stakeholders**

**Workers**

Being scolded by supervisors was identified as a major problem among workers, although they were reluctant to express it in the questionnaire. One worker said, “Please tell the supervisor not to talk so harshly to us,” while another commented, “Their words are so sharp they pierce my heart.” A few workers from one factory said they were happy and did not have problems with supervisors as they were understanding and created a pleasant work environment. This enabled them to complete their target. Most of the workers said they were able to bring only rice and one vegetable for lunch as they had hardly any time in the mornings. However almost all the workers interviewed said that during lunch break, three or four of them would get together and share their lunches, so that each gets at least two or three types of vegetables.

**Supervisors**

Most supervisors complained about problems with workers falling behind their given targets and that they are under pressure from management to complete the quota for the day. Consequently they were harsh with workers and this resulted in conflicts. Supervisors from some factories mentioned that workers often complained about the breakfast provided especially when green gram was served as they prefer carbohydrate rich items like buns and bread.

**Service providers**

The doctor attached to the government medical institution closest to the zone identified chest pain as a common cause for hospitalisation of workers. It was also observed that although workers get admitted, they tend to discharge themselves within two hours before examinations could be carried out. Hysterical attacks were quite common among workers and related to unpleasant incidents at work. Nurses reported that whenever they took workers to the occupational health centre for treatment, the junior staff were rude and abusive. This was one reason why workers were reluctant to visit the centre even though the doctors were kind and helpful.
Findings from the Health Providers’ Questionnaire

Six doctors were given a self-administered questionnaire; five of them are attached to the occupational health centre and the sixth is a private general practitioner who also provides medical services to FTZ workers. According to the questionnaire for FTZ workers, majority of them seek treatment from him. All of them said that the workers were satisfied with the services provided. Five of them were aware of the counselling centre, however only two had referred cases there. Five doctors saw an average of 60 to 75 patients each daily, while the other said he sees 90 patients daily. Three doctors stated that they spend between two to five minutes with each client, whereas two doctors said that they spend between seven to ten minutes. Suggestions by the doctors to improve services for the FTZ workers included providing them with mid-day meals, supplying them iron and folic acid tablets, creating awareness about the services at the occupational health centre, and conducting training and health education programmes.

Nine nurses from seven garment factories filled in the self-administered questionnaire. Suggestions for improving services included having a crèche or nursery for workers with children and having a doctor visit factories at least once a month to attend to women’s health problems. All nurses stated that the workers were satisfied with services provided and were aware of the counselling centre. Additionally, the dental surgeon at the centre confirmed that oral hygiene is poor among workers; hence there is a need for dental hygiene programmes.

Findings from Facility Check

Only three factories were chosen due to limited time. The term ‘medical centre’ was used for the centre where the medical officer visits twice a week. The other two centres are mainly for first aid cases. Here, basic equipment, such as the steriliser, blood pressure apparatus, weighing scale, stethoscope, spot lamp, suction apparatus and ambulance bag, are not available. Drugs are limited to a few analgesics, antacids, balms, ointments and vitamins. Clients’ records were not satisfactory either. There are no facilities at all the medical centres within the factories to conduct reproductive health clinics.

The cleanliness and attitude of staff is good. Having women nurses enabled women workers to discuss their problems freely. While medical facilities in the three factories visited catered only to the factory workers, the government medical facilities cater to the entire population. Staff and equipment are satisfactory, but reproductive health services need to be strengthened and expanded to include all aspects of reproductive health such as family planning, maternal health, and breast and cervical cancer screenings.

Researchers’ Observations

Relevant observations were made during visits to factories and factory medical centres. None of the factories had backrests for workers and sitting postures adopted were incorrect making workers prone to backache. When the researcher commented this to one of the nurses trained in occupational health problems, she merely told the workers to ‘straighten your back, straighten your back’ instead of demonstrating how to sit correctly. While some of the medical centre nurses had to deal with many workers, elsewhere only a few workers came for treatment.

Nurses did not make use of the training given to them on stress relief. When the researcher asked one nurse whether she was able to make use of the training given, she said, “Yes. I enlarged the handouts that were given at the training and put them up on the notice board so that all the workers could see them.” It is doubtful whether workers had the time to look at the diagrams or understand them.

At another clinic, the researcher observed a fairly senior nurse (who had participated in the training programme) at work. Though she was not rushed, she was more concerned in making entries in the register and handing out ointments and analgesics for headache and backache. Not once did she demonstrate to the worker who came for treatment how to do a head massage on themselves for headache, nor did she demonstrate back exercises for those who came with backache. At a factory medical centre one nurse had to attend to as many as 40 patients a day. She did not have the time to demonstrate any of the procedures taught and requested the researcher to examine those who had problems which she could not attend to. She said that the services of
a medical officer to visit the centre at least once a month is urgently required. Except for one medical centre visited, the other centres did not have facilities to ensure private consultations for women workers.

**RECOMMENDATIONS**

**Strengthening Health Services**

- The provincial director of health services (PDHS) needs to strengthen the occupational health centre and provide all facilities required to offer women a comprehensive health service which includes the reproductive health component.

- The Board of Investment to ensure that workers are more aware of the health facilities, including dental health services available at the occupational health centre, through posters and announcements over the public address system in factories.

- The Board of Investment to negotiate with the provincial director of health services for a medical officer to visit the factory medical centres on a regular basis.

- All factory health clinics should maintain basic records such as client register, giving name of client, complaint and drugs given. A simple uniform system needs to be developed. The Board of Investment to obtain assistance from the provincial director of health services on this matter and coordinate with the factory management.

- A record should be maintained for each worker to record medical treatment obtained at any service outlet, including government service outlets, medical centres within the factories and private medical practitioners. An exercise book could be used for this purpose and kept with the worker also.

- A referral system needs to be developed ensuring feedback from institutions to which clients have been referred. Provincial director of health services to discuss with factory management and send necessary directive to medical institutions servicing the area in the vicinity of the zone.

- Factory medical centres to provide facilities for privacy for medical examination of women workers.

- Factory management to ensure necessary drugs and equipment for their medical clinics are provided.

**Dissemination of Knowledge on Reproductive Health and other Relevant Issues**

- The Board of Investment to coordinate with the medical officer of health to provide talks on health topics relevant to the women workers at the factories through the public address system.

- The Board of Investment to liaise with editors of popular newspapers read by workers to include articles on health topics relevant to and requested by them.

**Reduce Occupational Health Problems**

- Wherever workload is heavy at medical clinics, an additional nurse or attendant to be provided by the management. Nurses who have a heavy workload should not be involved in duties other than nursing. This will enable nurses to demonstrate stress relief measures to those with backache, headache etc.

- Training on stress relief measures should be provided to those nurses who were not released to attend the previous programmes.

- Management to provide backrest chairs and teach the workers correct posture, how to carry weights etc. The Board of Investment could arrange for a physiotherapist to visit the factories regularly and give advise regarding stress relief measures and retrain the nurses as well.
Promotion of Workers' Mental Wellbeing

- The Board of Investment to organise workshops for supervisors from all factories, to meet and discuss their problems and share experiences and ideas on how to create a better and happier working environment for themselves and the workers.

- The Board of Investment to organise regular workshops for managers of all the factories so that they can exchange ideas to create a more gender-sensitive work environment.

Improvement of Nutritional State of Women Workers

- Factory management should continue to provide a well-balanced meal for breakfast and ensure that the quality of food is satisfactory for the benefit of all workers. An item of protein should be included in the breakfast. Also to continue providing the mid-morning and afternoon cup of tea with milk and a biscuit. Factories need to consult the workers as to what items they would like to have for breakfast.

- It is recommended that all factories offer women workers one tablet each of iron, folic acid and vitamin C daily. Before commencing this intervention, workers need to be made aware of the importance of taking these tablets. The medical officer of health or district director of health services could be requested to give short talks regarding this during working hours over the public address system.

- In addition to nutrition awareness programmes, recipes for cheap and easy to prepare nutritious foods need to be provided. Cooking demonstrations on soya products need to be expanded to all factories to benefit the entire workforce. Soya products too could be made available for sale to workers at the zone.

Coping with Problems

- Workers to be made aware of the counselling services available at the occupational health centre.

- Counsellors to get to know the factory management and the workers through factory visits. The Board of Investment to facilitate this process.

- Individual or group sessions can be held with workers who are keen to seek help from the counsellors, since workers are unable to visit the counselling centre during working hours.

- Counsellors to train nurses at the factory medical centres regarding listening skills and criteria for referral.

- Those who do not wish to discuss problems in a confidential manner should be able to obtain help through correspondence with the counsellors.

- Doctors to refer to counsellors those workers who need counselling to cope with their problems.

ACTIVITIES AND OUTCOMES

The four workshops held by researchers for doctors, nurse, supervisors and management to discuss the preliminary findings had the following positive outcomes:

- The provincial director of health services (PDHS) consented to release a doctor every three months to visit the factories with transportation provided by the factory management.

- Priority was given to FTZ workers to visit the nearby occupational health centre (OHC) by providing them a gate pass and a medical record book. Service hours were extended until 6:00 p.m. from the normal 4:00 p.m.

- Nurses attended workshops organised by management to improve their skills to provide effective care for stress-related workers problems of headache, backache, and tiredness.

- Doctors underwent stress management techniques demonstration and were informed of counselling services to facilitate referrals.
• The medical officer of health (MOH) agreed to visit factories once a month to give a 15-minute talk on the public address system on important health topics, and the first talk was on the Rubella Immunisation System.

• The awareness of the needs and rights of women workers to health care were raised through informal discussions with relevant stakeholders – the Board of Investment officials, service providers, women workers, supervisors and management.

REFERENCES


ADIC. 1997. “Negotiating for Safer Sex with Alcohol Users by Women in the FTZ”. Alcohol and Drugs Information Centre (ADIC).


FPA. (n.d.). Knowledge, Attitude and Practice of Family Planning Among Female Workers in the FTZ. Sri Lanka: FPA.

Women’s access to gender-sensitive and quality health care in the public sector services in Sindh, Pakistan

Hilda Saeed and Fauzia Rehman

INTRODUCTION

This study assesses the extent to which the Ministry of Health (MoH) and the Ministry of Population Welfare (MoPW) have integrated their functions and goals to improve women’s access to health services. The division of work between the two ministries in the past resulted in information dissemination and contraceptive supply by family planning outlets under the Ministry of Population Welfare, while ligation, vasectomy and treatment for reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) were available only at the Ministry of Health outlets. Facilities were often far apart and women needing both contraceptive and gynaecological services have to visit two centres, often a difficult exercise for both rural and urban women. The absence of a well-coordinated health delivery system with adequate referral linkages in rural areas also added to problems, as did inadequate transport and communication. By examining the operations of 14 government facilities, this research explores whether collaboration between the ministries has necessarily resulted in increased health access for women in Sindh and if the services are gender-sensitive given the commitments made at the International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women in Beijing.

COUNTRY CONTEXT

Poor women have identified insufficient access to health care as a constraint to service utilisation. On the other hand, ‘lack of demand’ for health services has often been cited as a reason for poor women not utilising services. Failure to use services has frequently been blamed on women’s illiteracy and cultural and religious beliefs. Women’s perceptions reveal that it is often
services that are insensitive to their needs, for example, the distance of the health facility from home or unsuitable opening hours. Women prefer non-governmental organisations' (NGO) facilities and report better treatment as they receive respect, sensitive counselling and consultation. The reason for limited or non-utilisation of services, other than the distance factor, may lie in restrictions to leave the home imposed by husband, male kin and other influential family members including the mother-in-law. The wide socio-cultural gap that exists between users and providers of health services also affects access.

Efforts have been instituted to bring in a reproductive health care approach to women’s health in keeping with the shift from family planning to reproductive health. Coordinated work between the Ministry of Population Welfare and Ministry of Health ensures the delivery of primary health care (PHC), reproductive health and family planning services. Functional integration is carried out through implementation and action at provincial, district and divisional levels. The package of reproductive health care based on ICPD objectives provides for comprehensive family planning services, safe motherhood, child health care; adolescent reproductive health management; female and male reproductive health management; prevention and management of RTIs/STDs, HIV/AIDS; infertility management; and cancer detection. At divisional and district levels in each province, both Ministry of Health and Ministry of Population Welfare work in close coordination to meet women’s reproductive health needs. The programme for family planning and primary health care provides training to family planning and primary health care workers whose responsibilities include ante- and postnatal care and childcare. In the primary health care sector, community health and family planning workers have been trained at five regional training centres and deployed in both rural and urban areas. Under the Ministry of Population Welfare scheme of village-based family planning workers (VBFPWs) initiated in 1992, training of traditional birth attendants (TBAs) in emergency care and referral is assured.

The building-up of gender specific empirical evidence and analyses reveals a systemic gender gap in the way burdens of disease are addressed (Table 1). Most governments deliver services in a top-down manner involving little dialogue with the users (especially women) on the definition of their needs. For example, the process of incorporating women into public policy has been extremely slow. In terms of health care, despite the slogans, political agreement and many good ideas, prevention of illness is a process that does not have the same visibility as treatment and cure. The measure of women’s health status is still typically the mere absence of disease. This neglect of women’s health concerns mirrors a gap, where the relationships between women and providers have not been addressed.

Table 1: Total burden of disease in Pakistan

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>%</th>
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<tbody>
<tr>
<td>Maternal and pre-natal care</td>
<td>13.0</td>
</tr>
<tr>
<td>STDs</td>
<td>02.0</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>04.0</td>
</tr>
<tr>
<td>Nutritional diseases</td>
<td>06.0</td>
</tr>
<tr>
<td>Neonatal tetanus</td>
<td>03.0</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>13.0</td>
</tr>
<tr>
<td>Respiratory infections</td>
<td>08.0</td>
</tr>
<tr>
<td>Other childhood diseases</td>
<td>04.0</td>
</tr>
<tr>
<td>Other communicable diseases</td>
<td>04.0</td>
</tr>
<tr>
<td>Other non-communicable diseases</td>
<td>33.0</td>
</tr>
<tr>
<td>Injuries</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
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</table>


According to the World Bank, Pakistan is one of the few countries in the world where men outnumber women. The Pakistan Demographic and Health Survey (PDHS) found that there are 108 men for every 100 women. This unfavourable ratio is mainly the product of high mortality of young girls and women of child bearing age. Mortality of females is 66 per cent higher than that of males between the ages of one and four, suggesting significantly less favourable treatment of girls than of boys. An analysis of the overall
disease burden affecting the population indicates that about 16 per cent of the total burden is associated with pregnancy-related conditions. This constitutes almost one third of the disease burden from communicable, maternal and prenatal causes.

STUDY GOALS AND RESEARCH QUESTIONS

The immediate objectives are to explore the level of collaboration between the Ministry of Population Welfare and Ministry of Health in Sindh in providing reproductive health care, and to assess women’s access to gender-sensitive and quality health care facilities and its impact on their lives. In the long term, the study aims to affect changes in the perceptions of health service providers and make women aware of their rights to gender-sensitive and quality health care services.

The study is based on the following research questions:

- What do disadvantaged/marginalised women in various stages of their life-cycle need, want and have a right to in terms of access to gender-sensitive, quality health care services?
- What are the main barriers and solutions to this access?
- What are the commonalities and differences in the perception of women users and health care providers about women’s needs as well as the barriers to access and the solutions to overcome them?

As women from the low-income strata utilise government health facilities and service delivery, the study aims to capture poor women’s experiences with access to health care.

RESEARCH FRAMEWORK

The Research Project Planning Meeting (ARROW, 1997) was held to assess women’s access to gender-sensitive and quality health care services at primary, secondary and tertiary levels.

<table>
<thead>
<tr>
<th>Data Analysis Tool</th>
<th>Accessibility</th>
<th>Gender-sensitive (based on women’s needs)</th>
</tr>
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<tbody>
<tr>
<td>Range of services</td>
<td></td>
<td></td>
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<tr>
<td>Technical competence</td>
<td></td>
<td></td>
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<tr>
<td>Inter-personal</td>
<td></td>
<td></td>
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<tr>
<td>Relationships</td>
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<tr>
<td>Continuity of</td>
<td></td>
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<tr>
<td>Care/Follow-up</td>
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<tr>
<td>Infrastructure</td>
<td></td>
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<tr>
<td>Management</td>
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<thead>
<tr>
<th>Variables of Research</th>
<th>Health Services (quality of care)</th>
<th>Gender-sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance</td>
<td>Infrastructure available, adequacy of:</td>
<td>Macro level (Planning Commission, MoH, MoPW, MoWD), Latest health policy/ current population policy</td>
</tr>
<tr>
<td></td>
<td>• Health facilities • Equipment • Drugs</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Reproductive health/ Family planning facilities</td>
<td>Provincial picture (P&amp; D Dept, DoH, DoPW, DoWD, NGOs)</td>
</tr>
<tr>
<td>Transport</td>
<td>Treatment for STDs/ HIV/ AIDS</td>
<td>Allocation of resources (budget, health staff, drugs, and supplies)</td>
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<tr>
<td>Knowledge</td>
<td>Nutrition at household level</td>
<td>Health budget for women’s health vs. overall budget</td>
</tr>
<tr>
<td>Cost</td>
<td>Immunisation</td>
<td>Health staff. Proportion of women health workers vs. total health</td>
</tr>
<tr>
<td>Autonomy to decide to seek health care</td>
<td>Comprehensiveness of services, including emergency rooms</td>
<td>Training to health staff</td>
</tr>
<tr>
<td>Mobility/cultural norms</td>
<td>Emergency obstetrics care</td>
<td>Treatment, attitudes of service providers</td>
</tr>
<tr>
<td>Awareness of existence of services</td>
<td>Violence against women</td>
<td>Extent to which women providers are available for medical examination and childbirth, etc. (if women express such a preference)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extent of gender bias of service availability and/or provision towards a particular sex</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Range of male and female service providers in various levels and categories and extent of male-female hierarchy</td>
</tr>
</tbody>
</table>
RESEARCH METHODOLOGY

A convenience sample of health facilities was selected due to budget constraints. However, all four divisions of Sindh were considered while choosing the research sites: Sukkur, Larkana, Hyderabad and Karachi. Fourteen government facilities at primary, secondary and tertiary levels in Sindh that had implemented some or all components of the Reproductive Health Package and attempted to integrate facilities provided by the Ministry of Health and Ministry of Population Welfare.

The study employed a women-centred², participatory and action-oriented approach to gather data and analyse the empirical evidence. Questionnaires to women users, health providers and key informants were kept as participatory as possible. While largely quantitative, the study also included qualitative information collated through in-depth interviews.

Questionnaires were based on the ARROW research framework and an initial visit was made to various service outlets. Questionnaires were sent in advance to key informants and supervisors of each service outlet. Fourteen keen informants, 40 service providers and 236 women users at three tertiary, six secondary and five primary care facilities, responded to questionnaires.

Sindh was selected as the study area for the following reasons:
• It is Pakistan's second largest province with four large urban cities. However, basic indicators including those for women's health, appear lower than those of Punjab, the other heavily-populated province.
• Social disempowerment of women is considerable, particularly in the rural areas. Specific types of violence against women (VAW) are characteristic to this region and negate women's access to reproductive health care.
• Functional integration of the Ministry of Population Welfare and Ministry of Health at district and divisional levels is operational there.

DATA COLLECTION

Fieldwork began in May 1998 and was completed in April 1999. Appointments were made with the medical superintendent or medical officer in each facility to introduce the study and seek cooperation. Hospital records from three hospitals were accessed to select users.

The study team comprised a full-time research assistant with social work experience and a senior researcher with public health expertise and considerable field experience in Sindh and other areas. A senior Shirkat Gah coordinator provided overall guidance and supervised the study. Consent to conduct the survey was given by heads of divisions (Divisional Directors of Health Services (DDHS) and administrators of the concerned facility (medical superintendent, medical officer, or woman medical officer in-charge). Data collection was done with informed consent of both providers and users.

Questionnaires

The questionnaire for service providers sought quantitative and qualitative information about available services in reproductive health and family planning. Medical supervisors and other hospital staff members were also interviewed. The questionnaire for women users was designed in simple Urdu. However, during interviews in the interior of Sindh, it occasionally became necessary for a Sindhi-speaking interviewer to translate questions. The questionnaire assessed service quality, access and barriers to access.

Interviews

Prior to conducting the field study, 14 key informants including provincial planners, senior and junior health providers, an activist, a psychologist and NGO health workers were interviewed. The purpose of interviewing key informants was to ascertain the prevailing status of problems and to incorporate views of experts in the final report. The interviews with the 14 women provided information on gender-based discrimination and violations as there was reluctance to respond to such sensitive issues in the questionnaire. They offered insights into the personal histories, values and perceptions of users and service providers and gave information on the operation of health care centres.
Sample Size of Women Users

Research team members spent several weeks interviewing the women from different ethnic and cultural backgrounds who accessed services at public hospitals and health centres.

**Table 2: Sample size**

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>No. of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 KMC Sobhraj Maternity Home, Karachi</td>
<td>20</td>
</tr>
<tr>
<td>2 KMC Abbasi Shaheed Hospital, Karachi</td>
<td>20</td>
</tr>
<tr>
<td>3 Sindh Govt. Hospital, Liaquatabad, Karachi</td>
<td>20</td>
</tr>
<tr>
<td>4 Sindh Govt. Services Hospital, Karachi</td>
<td>20</td>
</tr>
<tr>
<td>5 Shaikh Zaid Women's Hospital, Larkana</td>
<td>20</td>
</tr>
<tr>
<td>6 BHU Dhamra, Taluka Larkana</td>
<td>11</td>
</tr>
<tr>
<td>7 Taluka Hospital Dokri, Larkana</td>
<td>13</td>
</tr>
<tr>
<td>8 Taluka Hospital Ghotki, Sukkur</td>
<td>20</td>
</tr>
<tr>
<td>9 RHC Bachal Shah Miani, Sukkur</td>
<td>11</td>
</tr>
<tr>
<td>10 BHU Abad, Taluka Sukkur</td>
<td>7</td>
</tr>
<tr>
<td>11 Civil Hospital, Sukkur</td>
<td>14</td>
</tr>
<tr>
<td>12 RHC Matiari, Hyderabad</td>
<td>20</td>
</tr>
<tr>
<td>13 CDF Hospital, Hyderabad</td>
<td>20</td>
</tr>
<tr>
<td>14 Liaquat Medical College Hospital, Hyderabad</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>236</strong></td>
</tr>
</tbody>
</table>

**LIMITATIONS**

The survey sample was limited in its scope. However, it provides the basis for conducting a similar study and provides a sketch of the existing situation including the need for inclusion of gender-sensitisation in the present reproductive health service package.

While an attempt was made to understand the extent and types of violence and abuse of women, (through key informant interviews and a separate specific questionnaire to obtain and understand its link to reproductive health and reproductive rights), the main questionnaire was unable to further probe some issues that would have had significant relevance to the study, since most women users were hesitant to answer such sensitive gender-related questions. Women at the health centres rarely discussed their views with researchers. While this study is not able to highlight the voices of women prominently, nevertheless, it highlights women's conditions and the socio-cultural barriers they face in their access to quality services available. Moreover not all hospitals were willing to share records. Only a few centres maintained registers and shared their information.

Certain findings are relevant to the contextual situation of the time the study took place, for example, functional integration, which was then at an initial stage in process, has now been completed successfully. Some national statistics have also changed, for example, a recent survey called the Fertility and Family Planning Survey conducted in 1996 - 1997 reported the contraceptive prevalence rate (CPR) as 23.7 per cent compared to earlier surveys in 1984 – 1985 (9.1 per cent), 1990 - 1991 (11.8 per cent) and 1994 – 1995 (17.7 per cent).

Socio-cultural barriers, extremely disparate gender ratios and high extent of violence against women has resulted in an atmosphere of fear in which women live. The fact that policies have also rendered them subservient (women's literacy rate is half that of men's and nothing is being done by the Education Ministry to deal with it) exacerbates their marginal position in society.

**FINDINGS**

**Information from Key Informants**

The 14 key informants felt most women were unaware of health problems and available medical facilities. They identified barriers to access to be gender-biased traditions and customs, and dominance of family members particularly the mother-in-law, husband and male kin. Family members do not consider it necessary for women to visit a health centre. In addition, individual family traditions and poverty also affect access. A significant point noted was the
unfriendly environment in hospitals. Most hospitals are not women-friendly and lack basic facilities such as chairs, supplies and staff.

The incidence of maternal deaths is high in Pakistan and is attributed to early marriage and gender-discriminative practices. Women are frequently anaemic and malnourished, and with every pregnancy especially closely spaced ones, the risk of maternal mortality increases. Approximately 85 per cent of childbirths are attended by untrained traditional birth attendants who are unable to identify high-risk pregnancies. Even when trained traditional birth attendants give referrals, the lack of well-equipped district hospitals exacerbates the situation, particularly the lack of emergency obstetrics care (EOC). This situation can lead to severe complications and even death. Distance and inadequate transport facilities also deter women from accessing urban hospitals.

The high fertility may be due to the following factors: lack of education and awareness; lack of development and communication systems; lack of public health facilities; preference for male children; religious beliefs; unmet need for contraception; fears of side effects of contraceptives; and inadequate provision of EOC facilities.

The overall percent of any contraceptive method ever used increased from 11.8 per cent in 1984 - 1985 to 36.4 per cent in 1996. The 1997 Pakistan Fertility and Family Planning Survey (PFFPS) revealed that 93 per cent of women are aware of at least one family planning method. However, many women do not visit health centres for family planning needs because of inadequate family planning counselling and distribution facilities, and reluctance to seek and practise contraception.

The Departments of Population Welfare and Health at the provincial level now have stronger cooperation and collaboration at district and divisional levels but complete integration has not yet been achieved. Space is provided for family planning centres in government hospitals by the health department. Government hospitals offer family planning and other reproductive health services at health centres while the population department’s family planning centres provide counselling, examination and contraceptives. The provincial population departments also maintain strong links with NGOs, which provide family planning services including the Family Planning Association of Pakistan (FPAP), PAVHNA, Marie Stopes, Pak Medicos, Behbud Association and the Social Marketing Programme.

Although reliable published data regarding prevalence of RTIs and STDs is not available, the key informants identified some contributory risk factors, including low level of awareness, unsafe sexual practice, high-risk sexual behaviour, unsafe abortions (abortion is illegal in Pakistan), unhygienic deliveries by untrained dais, unhygienic living conditions, illiteracy, poverty; malnutrition and inadequate diagnostic, screening and treatment facilities.

In addition, poor access to health care and insufficient public awareness lead to cases of RTIs that are undetected and untreated, resulting in increased susceptibility to infection and subsequent morbidity and mortality. Women who complain of abnormal vaginal discharge are sometimes unable to differentiate between normal and abnormal discharge. They may confuse normal vaginal discharge with menstruation, pregnancy, lactation or sexual intercourse, and consider it abnormal. Cases of RTIs are also seen in unmarried girls, especially bacterial vaginosis. The need for greater male responsibility especially for antenatal care or for contraception for partners was therefore stressed. It could be made a condition that men accompany wives for at least two antenatal check-ups to help them understand that pregnancy is a major phenomenon in the lives of women. The importance of spacing childbirth and providing more attention to women’s nutritional and other needs were suggestions made to improve women’s maternity conditions. Counselling needs to be the focus of all programmes and service providers should be trained in interpersonal skills and counselling. Generally, women and men are both shy about discussing issues regarding reproductive health and sexuality, so client privacy will enable them to speak freely.

Malnutrition affects adult women more than men because of childbirth, child rearing, house keeping and poverty. The key informants perceived women’s malnutrition as part of a vicious cycle: a woman is malnourished and anaemic during pregnancy and gives birth to low birth weight babies; the short interval between pregnancies makes her more malnourished, leading to potential complications in childbirth. The major contributing factors are poverty, unequal
intra-household food distribution practices and general lack of awareness of nutrition. People often have wrong perceptions about nutrition, and, consequently, adolescent girls and expectant mothers may be deprived of adequate nutritional requirements.

The concept of ‘violence’ has gained wider meaning and comprises not only physical violence but also verbal, psychological and emotional abuse. As violence is about control and power, women victims are often isolated, threatened and intimidated. Domestic violence cuts across all class barriers and affects the rich, professional, and poor, uneducated people equally. Some people still refuse to recognise violence against women as a problem, and it is an issue not generally discussed in public. Cultural barriers hinder women from speaking up. Common fears are shame, stigma, being considered a bad woman, a failed woman, and being blamed for it. Accessing legal aid is almost impossible for the average woman. Discussions with key informants and Shirkat Gah staff involved in women’s law and environment programmes pointed to the need for raising public awareness and changing public attitudes and mindsets through the media and education.

Main Survey Findings

Collaboration of the Ministry of Health and Ministry of Population Welfare

Functional integration is successful because of the wider range of reproductive health care facilities available at each health centre. Given the high demand for such facilities, primary health care and reproductive health services need to be further enhanced; supplies, services and staff are still insufficient. Facilities for pre- and post-natal care and for delivery need to be increased for optimal health care. A large proportion of the family monthly income is allocated for private health care because of inaccessibility, inadequacy of services and people’s reliance on traditional healers.

Access and barriers

Progress was noted in women’s access to health services given the investments made in infrastructure development particularly in the increased number of basic health units (BHUs) and rural health centres (RHCs) in the rural areas.

According to health providers (Table 3) and borne out by personal observation, most facilities (93.5 per cent) reported go to 100 per cent coverage with some or all elements of reproductive health care. However, problems related to staffing and quality of care persist and even where geographical coverage of access has increased, much remains to be done to improve functional integration of primary health care and reproductive health services. In many facilities reproductive health services are still provided on an ad-hoc basis. About 90 per cent of facilities provide some types of family planning services. Table 4 shows the methods of family planning available at the 14 facilities.

Table 3: Services available (N=14 facilities)

<table>
<thead>
<tr>
<th>Service</th>
<th>No. of facilities providing each service</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Pathological/Radiological laboratory</td>
<td>13</td>
<td>92.9</td>
</tr>
<tr>
<td>X-ray, ultrasound, ECG</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Immunisation</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Counselling for breast-feeding</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Weighing in pregnancy</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Blood pressure taken in pregnancy</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Urine test in pregnancy</td>
<td>13</td>
<td>92.9</td>
</tr>
<tr>
<td>Supply of iron folate tablets in pregnancy</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Family planning services</td>
<td>13</td>
<td>92.9</td>
</tr>
</tbody>
</table>

Table 4: Family planning methods available (N=14 facilities)

<table>
<thead>
<tr>
<th>Type</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptives (progesterone-estrogen)</td>
<td>13</td>
<td>92.9</td>
</tr>
<tr>
<td>Oral contraceptive (progesterone only)</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Injectable (progesterone-estrogen)</td>
<td>6</td>
<td>42.9</td>
</tr>
<tr>
<td>Injectable (progesterone only)</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Condom</td>
<td>12</td>
<td>85.7</td>
</tr>
<tr>
<td>IUD</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Implant (NORPLANT)</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Sterilisation</td>
<td>12</td>
<td>85.7</td>
</tr>
</tbody>
</table>
Tables 5 and 6 highlight gaps in service utilisation that prevent women from exercising their health rights. These tables were obtained from the medical records or the Health Information Management System (HMIS) available in the facilities.

Table 5 shows a marked contrast in the number of antenatal check-ups against the number of actual deliveries taking place in the hospitals and the number of postnatal check-ups. Even in facilities where the number of antenatal check-ups are as high as 1,557, the number of deliveries reported is 152, whereas the number of postnatal check-ups is even lower at 55. There may not be enough attention or resources given to delivery as compared to prenatal care, or women may prefer to get prenatal care in the hospital but deliver at home. The constraining factors that restrict access may stem from both women’s and family members’ attitudes towards health needs.

Socio-economic characteristics of respondents
The analyses in Tables 7 to 9 point to the social construction of gender needs and roles which leads to low levels of female education and male bias and dominance in decision-making. These factors contribute further to restraining women’s access to health care services.

Table 5: Reproductive health services provided (during the last month preceding the survey) (N=14 facilities)

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Antenatal</th>
<th>Deliveries</th>
<th>Postnatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMC Sobhraj Maternity Home, Karachi</td>
<td>800</td>
<td>450</td>
<td>250</td>
</tr>
<tr>
<td>KMC Abbasi Shaheed Hospital, Karachi</td>
<td>1,030</td>
<td>218</td>
<td>Record N/A</td>
</tr>
<tr>
<td>Sindh Govt. Hospital, Liaquatabad, Karachi</td>
<td>1,200</td>
<td>100</td>
<td>Record N/A</td>
</tr>
<tr>
<td>Sindh Govt. Services Hospital, Karachi</td>
<td>600</td>
<td>39</td>
<td>Record N/A</td>
</tr>
<tr>
<td>Shaikh Zaid Women’s Hospital, Larkana</td>
<td>262</td>
<td>187</td>
<td>0</td>
</tr>
<tr>
<td>BHU Dhamra, Taluka Larkana</td>
<td>56</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Taluka Hospital Dokri, Larkana</td>
<td>59</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Taluka Hospital Ghotki, Sukkur</td>
<td>133</td>
<td>62</td>
<td>98</td>
</tr>
<tr>
<td>RHC Bachal Shah Miani, Sukkur</td>
<td>117</td>
<td>65</td>
<td>54</td>
</tr>
<tr>
<td>BHU Abad, Taluka Sukkur</td>
<td>12</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Civil Hospital, Sukkur</td>
<td>491</td>
<td>78</td>
<td>158</td>
</tr>
<tr>
<td>RHC Matiari, Hyderabad</td>
<td>*Record N/A</td>
<td>7</td>
<td>Record N/A</td>
</tr>
<tr>
<td>CDF Women’s Hospital, Hyderabad</td>
<td>1,557</td>
<td>152</td>
<td>55</td>
</tr>
<tr>
<td>Liaquat Medical College Hospital, Hyderabad</td>
<td>Record N/A</td>
<td>366</td>
<td>Record N/A</td>
</tr>
</tbody>
</table>

*Record N/A: Record Not Available
Table 7 shows that women’s illiterate status was common (54 per cent of respondents were illiterate), while Table 7 reveals that very few women earned an income (12.3 per cent). The majority of them (87.3 per cent) are housewives who maintained the home, the farm and livestock. As evident from the interviews, economic position plays an important role in defining gender relations in the household. Women who do not earn an income attach less value to themselves and their wellbeing relative to the wellbeing of those who earn an income. Such perceptions that render women subservient, operate in varying degrees in different households and tend to be prevalent in traditional rural households. Table 8 shows that nearly half the respondents (42 per cent) are shown to live on a monthly income of Rs. 1000-3000.

### Table 7: Educational level of Respondents (N=236 women)

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>128</td>
<td>54.2</td>
</tr>
<tr>
<td>Up to Class 5</td>
<td>33</td>
<td>14.0</td>
</tr>
<tr>
<td>6-8 Classes</td>
<td>21</td>
<td>8.9</td>
</tr>
<tr>
<td>9-10 Classes</td>
<td>29</td>
<td>12.3</td>
</tr>
<tr>
<td>11-12 Classes</td>
<td>19</td>
<td>8.1</td>
</tr>
<tr>
<td>13-14 Classes</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 8: Occupational status of respondents (N=236 women)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Income earning</td>
<td>29</td>
<td>12.3</td>
</tr>
<tr>
<td>Housewives</td>
<td>206</td>
<td>87.3</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 9: Household Income of Respondents (N=236 women)

<table>
<thead>
<tr>
<th>Income in Pak. Rupees (Rs)</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1000</td>
<td>11</td>
<td>4.7</td>
</tr>
<tr>
<td>1001 – 3000</td>
<td>100</td>
<td>42.4</td>
</tr>
<tr>
<td>3001 – 6000</td>
<td>69</td>
<td>29.2</td>
</tr>
<tr>
<td>6001 – 9000</td>
<td>17</td>
<td>7.2</td>
</tr>
<tr>
<td>9001+</td>
<td>16</td>
<td>6.8</td>
</tr>
<tr>
<td>Do not know income</td>
<td>23</td>
<td>9.7</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 10 shows the complex matrix of relationships in a household set by gender, age, kinship and association. Households vary in composition, from nuclear units of single couples, to those of parents and children and those with additional relatives, siblings and grandparents. Household decisions are made by consensus or by the head of the household who is generally a male. Household stability is linked to the maintenance of gender relations, or in other words, unequal resources and power positions between women and men. This cultural practice or trend of living in extended families influences decision-making as the opinion of more than one person is sought. The predominant type of family structure is the extended or joint family. A large portion of the respondents (64.4 per cent) lived in extended families, which means greater degree of interference from other family members in all decision-making. Depending on economic level of the family and the nature of individual members, the outcome of such joint living can be either fruitful and worthwhile or difficult and negating for the wife. Young brides are expected to adjust to the new family despite facing unexpected and unnecessary criticism. Psychiatrists consider this to be a factor in women’s depression.

### Table 10: Type of families of respondents (N=236 women)

<table>
<thead>
<tr>
<th>Type</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended</td>
<td>152</td>
<td>64.4</td>
</tr>
<tr>
<td>Nuclear</td>
<td>84</td>
<td>35.6</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>
As shown in Table 11, large family size, averaging seven persons per household was found in nearly 40 per cent of cases. Large family size also becomes a burden on the finances of the family, thus restraining the household members from enjoying a number of facilities had they had a smaller family size.

Table 11: Household size of the respondents
(N=236 women)

<table>
<thead>
<tr>
<th>No. of persons in the HH including the respondent</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>10</td>
<td>4.2</td>
</tr>
<tr>
<td>3-6</td>
<td>73</td>
<td>30.9</td>
</tr>
<tr>
<td>7-10</td>
<td>94</td>
<td>39.8</td>
</tr>
<tr>
<td>11-14</td>
<td>38</td>
<td>16.1</td>
</tr>
<tr>
<td>15+</td>
<td>20</td>
<td>8.5</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Health care-seeking characteristics of respondents
The study encountered a large proportion (69.9 per cent) of women who were in various stages of pregnancy (Table 17). Though 90 per cent of the facilities provided some family planning services (Table 3), only 27.5 per cent of respondents used a modern method of family planning (Tables 12). For the 65 women using modern FP methods (Table 13), the methods used most frequently were condoms (29.2 per cent), injectables (18.5 per cent) and oral contraceptives (16.9 per cent).

Table 12: Family planning practices (N=236 women)

<table>
<thead>
<tr>
<th>Status</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practising</td>
<td>65</td>
<td>27.5</td>
</tr>
<tr>
<td>Not practising</td>
<td>170</td>
<td>72.1</td>
</tr>
<tr>
<td>Do not know</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 13: Types of family planning methods used (N=65 women)

<table>
<thead>
<tr>
<th>Method</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td>19</td>
<td>29.2</td>
</tr>
<tr>
<td>Injectable</td>
<td>12</td>
<td>18.5</td>
</tr>
<tr>
<td>Pill</td>
<td>11</td>
<td>16.9</td>
</tr>
<tr>
<td>Copper ring</td>
<td>7</td>
<td>10.8</td>
</tr>
<tr>
<td>Surgical sterilisation</td>
<td>5</td>
<td>7.7</td>
</tr>
<tr>
<td>IUD</td>
<td>3</td>
<td>4.6</td>
</tr>
<tr>
<td>Mixed methods</td>
<td>8</td>
<td>12.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>65</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 14 indirectly indicates the extent these women are able to practice birth control. About one third of the respondents (33 per cent) had more than four children. Women's knowledge of contraception may be limited as those who were able to access information and contraceptives through community health workers seemed more articulate about their needs and discussed these with health personnel.

Table 14: Average number of children born per respondent
(N=236 women)

<table>
<thead>
<tr>
<th>No. of children</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>60</td>
<td>25.4</td>
</tr>
<tr>
<td>Up to 1</td>
<td>39</td>
<td>16.5</td>
</tr>
<tr>
<td>2-3</td>
<td>60</td>
<td>25.4</td>
</tr>
<tr>
<td>4-5</td>
<td>39</td>
<td>16.5</td>
</tr>
<tr>
<td>6-7</td>
<td>21</td>
<td>8.9</td>
</tr>
<tr>
<td>8-9</td>
<td>11</td>
<td>4.7</td>
</tr>
<tr>
<td>10-11</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 15 implies that access to hospitals is still inadequate with only half the respondents being able to access health facilities. A large proportion of
respondents delivered their last child at home (46 per cent) while deliveries in government hospitals accounted for 40.1 per cent. However, as the previous tables show there may be a number of social, economic and cultural factors contributing to such limited access. These factors may range from restricted mobility of women, their lack of decision-making powers, inadequate understanding of health needs, to poor quality and lack of gender-sensitive services available.

Table 15: Place of last delivery (N=187 women)

<table>
<thead>
<tr>
<th>Place</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>86</td>
<td>46.0</td>
</tr>
<tr>
<td>Government hospital</td>
<td>75</td>
<td>40.1</td>
</tr>
<tr>
<td>Private hospital</td>
<td>13</td>
<td>7.0</td>
</tr>
<tr>
<td>Govt. health centre (BHU, RHC)</td>
<td>11</td>
<td>5.9</td>
</tr>
<tr>
<td>Private clinic</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>187</td>
<td>100.0</td>
</tr>
</tbody>
</table>

From 1998 onwards the commitment to women’s health became visible, with emphasis on training of traditional birth attendants and provision of antenatal care and contraceptives following a directive to all federal ministry provincial departments to incorporate population activities in sectoral programmes. A Ministry of Health survey concluded that traditional birth attendants or dais assisted 80 per cent of deliveries. In terms of the number of deliveries, this translates into three million births managed by a cadre of illiterate, middle-aged women who learnt the skills from relatives or through self-learning.

In view of this the Ministry of Health launched a training programme in 1983 under the national Accelerated Health Programme (AHP). This initiative continued with UNICEF assistance and trained traditional birth attendants to identify pregnancies and refer women to secondary or tertiary health centres where necessary and assist in hygienic and safe delivery. It was found that the attitude and practices of the trained traditional birth attendants proved to be better than those of untrained dais. Trained traditional birth attendants provided advice on child immunisation, TT injections during pregnancy and counselling for family planning. Approximately 4,500 traditional birth attendants have been trained so far, and it is generally agreed by the workers in the population sector that they have contributed significantly to the country’s improved contraceptive prevalence rate (CPR).

Traditional birth attendants are usually culturally-accepted and are able to conduct normal vaginal delivery (NVD). Table 16 shows over 82 per cent respondents had NVD.

Table 16: Type of last delivery (N=182 women)

<table>
<thead>
<tr>
<th>Type</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal vaginal delivery (NVD)</td>
<td>150</td>
<td>82.4</td>
</tr>
<tr>
<td>Surgical delivery</td>
<td>32</td>
<td>17.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>182</td>
<td>100.0</td>
</tr>
</tbody>
</table>

For a significant majority of respondents, the single most important reason for attending the facilities was their current pregnancies (Tables 17 and 18). Out of 236 respondents visiting the health facility, more than half of them (70%) were pregnant.

Table 17: Pregnancy status of Respondents (N=236 women)

<table>
<thead>
<tr>
<th>Status</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant</td>
<td>165</td>
<td>69.9</td>
</tr>
<tr>
<td>Not pregnant</td>
<td>69</td>
<td>29.2</td>
</tr>
<tr>
<td>Do not know</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 18: Purpose of current visit to the facility (N=236 women)

<table>
<thead>
<tr>
<th>Reason</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal/Postnatal check-up</td>
<td>147</td>
<td>62.2</td>
</tr>
<tr>
<td>Bleeding problems</td>
<td>18</td>
<td>7.7</td>
</tr>
<tr>
<td>Admission for delivery</td>
<td>17</td>
<td>7.2</td>
</tr>
<tr>
<td>Post operative check-up</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Post abortion treatment</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Infertility treatment</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>STD treatment</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Piles treatment</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Fever/Pain/Weakness</td>
<td>24</td>
<td>10.2</td>
</tr>
<tr>
<td>Family planning services</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Sterilisation</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>Injection</td>
<td>9</td>
<td>3.8</td>
</tr>
<tr>
<td>Do not know</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As Table 18 indicates, the major reason for women visiting the health care facilities and their definition of disease remains to be mere absence of symptoms. The purpose of the visit by the majority of women (62.2 per cent) was antenatal and postnatal check-ups, followed by 10.2 per cent who came for the treatment of fever, pain and weakness and 7.7 per cent of respondents were there to seek treatment for bleeding problems: health concerns for which symptoms evidently exist. However, consultation for post operative check-ups, post abortion treatments and other ailments that are socially stigmatised, like availing family planning and sexually transmitted diseases treatments so are rarely utilised.

Table 19 shows that most of the respondents consulted private physicians (46 per cent) or government hospitals (33 per cent). Table 20 shows that most of them (around 30 per cent) spent approximately 100 Rupees for per visit to the doctor. This being a fairly large amount for a person from a low-income group is thus yet another barrier to limited access or low utilisation of services.

Table 19: Sources of medical treatment during last illness (N=236 women)

<table>
<thead>
<tr>
<th>Source</th>
<th>Number of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private physician</td>
<td>109</td>
<td>46.2</td>
</tr>
<tr>
<td>Government hospital</td>
<td>78</td>
<td>33.1</td>
</tr>
<tr>
<td>Government health centre</td>
<td>31</td>
<td>13.1</td>
</tr>
<tr>
<td>Hakeem</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Homeopath</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Dispenser/LHV</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>Do not know</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 20: Expenses on medical treatment (per visit) (N=236 women)

<table>
<thead>
<tr>
<th>Amount in Pakistani Rs.</th>
<th>Number of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-50</td>
<td>21</td>
<td>8.9</td>
</tr>
<tr>
<td>51-75</td>
<td>29</td>
<td>12.3</td>
</tr>
<tr>
<td>76-100</td>
<td>74</td>
<td>31.4</td>
</tr>
<tr>
<td>101-150</td>
<td>22</td>
<td>9.3</td>
</tr>
<tr>
<td>151-300</td>
<td>29</td>
<td>12.3</td>
</tr>
<tr>
<td>301+</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>Do not know</td>
<td>49</td>
<td>20.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Socio-cultural variables of access**

Pakistan’s health care system remains largely biomedical in its approach; there is a need to incorporate social and cultural factors including gender dynamics into the present scenario for women to fully access health care. Women’s articulation of their needs is often limited, consequently, few women access prenatal or postnatal care, or post abortion treatment.
The following tables highlight family attitudes and behaviour (Tables 21-25).

Table 21 shows that women generally lack decision-making power. Their decisions to visit the health facility are influenced most prominently by their husbands (57.6 per cent) and to some extent by other family members. However, some respondents (28 per cent) had autonomously taken the decision to visit the health facility.

Table 21: Decision to visit health facility (N=236 women)

<table>
<thead>
<tr>
<th>Decision taken by</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>136</td>
<td>57.6</td>
</tr>
<tr>
<td>Respondent</td>
<td>66</td>
<td>28.1</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>15</td>
<td>6.3</td>
</tr>
<tr>
<td>Mother of respondent</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Son of respondent</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Other relatives</td>
<td>11</td>
<td>4.7</td>
</tr>
<tr>
<td>Do not know</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Economic constraints, low levels of female education, illiteracy of more than half the women interviewed (54.2%) and lack of decision-making powers result in women's restricted mobility and thus limited access. Husbands often decided for their wives: 57.6% of respondents visited the facility with their husbands' permission. Evidently, women's visits to health care facilities are constrained because of home and childcare responsibilities influenced by social mores that limit mobility. Attending health clinics requires a full day and may include travel to other towns or district headquarters hospitals. Independent travel outside the home is rare for women (Tables 22 and 23).

Table 22: People who accompanied the respondents (N=236 women)

<table>
<thead>
<tr>
<th>Respondent accompanied by</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>54</td>
<td>22.8</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>29</td>
<td>12.3</td>
</tr>
<tr>
<td>Mother</td>
<td>38</td>
<td>16.1</td>
</tr>
<tr>
<td>Son/Daughter</td>
<td>13</td>
<td>5.5</td>
</tr>
<tr>
<td>Other relatives</td>
<td>88</td>
<td>37.3</td>
</tr>
<tr>
<td>Came alone</td>
<td>14</td>
<td>6.0</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

A considerable proportion of respondents (51.3%) did not have permission to go outside the home without being accompanied by a family member. Some 37.3% respondents were accompanied by a relative. In 22.8% of cases, husbands accompanied wives and mothers-in-law accompanied 12.3% of respondents. This has serious implications for women's health-seeking behaviour as women have to rely on others to access health care. Women also refrain from speaking in public and do not discuss problems with health providers and get older women to speak for them. According to the respondents, health providers make little attempt to draw women into discussions about their health. Social restrictions on women including purdah and seclusion circumscribe women's interactions with health providers, women's articulation of health needs and their access to health care.

Table 23: Mobility of respondents (N=236 women)

<table>
<thead>
<tr>
<th>Status</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permission to go outside the home alone</td>
<td>114</td>
<td>48.3</td>
</tr>
<tr>
<td>Not allowed to go outside the home alone</td>
<td>121</td>
<td>51.3</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Chapter 7: Pakistan
Tables 24 and 25 show that gender inequalities are also very apparent in everyday practices within the households. In 27.5 per cent of the households of respondents, men eat first. However 47.5 per cent of the respondents’ family members eat together. Special preference is given to male members of the family in the quality of food served, according to 13 per cent of the respondents. The generally-held beliefs about legitimate share in household resources, for example, quality and quantity of food, are linked to perceptions of gender roles and needs. Women get less because they are seen, both by themselves and men, as deserving less. They also consciously sacrifice individual interests for the interests of other household members. Such perceptions and practices have serious and long-term adverse impact on their health.

**Table 24: Intra-household food distribution pattern (N=236 women)**

<table>
<thead>
<tr>
<th>Type</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All household members eat together</td>
<td>112</td>
<td>47.5</td>
</tr>
<tr>
<td>Men eat first</td>
<td>65</td>
<td>27.5</td>
</tr>
<tr>
<td>Children eat first</td>
<td>42</td>
<td>17.8</td>
</tr>
<tr>
<td>No fixed pattern</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Table 25: Gender/age differences in types of food consumed by household (N=236 women)**

<table>
<thead>
<tr>
<th>Status</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No difference</td>
<td>204</td>
<td>86.5</td>
</tr>
<tr>
<td>Meat dishes served to men only</td>
<td>31</td>
<td>13.1</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Gender hierarchies at service level**

Findings from the hospital questionnaire include a gender disaggregation of services. There is evidence of gender disparity in both staffing patterns and services. Table 26 gives the gender data in the Outpatients Department in the number of male/female patients in the 14 government health care facilities, whereas Table 27 gives gender disaggregation in allocation of beds for male/female patients against the number of patients in each facility.

**Table 26: Gender disaggregation in Outpatients Department attendance during the month preceding the survey (N=14 facilities)**

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Male Patients</th>
<th>Female Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMC Sobhraj Maternity Home, Karachi</td>
<td>8800</td>
<td>2484</td>
</tr>
<tr>
<td>KMC Abbasi Shaheed Hospital, Karachi</td>
<td>5907</td>
<td>7611</td>
</tr>
<tr>
<td>Sindh Govt. Hospital, Liaquatabad, Karachi</td>
<td>3119</td>
<td>3091</td>
</tr>
<tr>
<td>Sindh Govt. Services Hospital, Karachi</td>
<td>1780</td>
<td>1780</td>
</tr>
<tr>
<td>Shaikh Zaid Women's Hospital, Larkana</td>
<td>286</td>
<td>469</td>
</tr>
<tr>
<td>BHU Dhamra, Taluka Larkana</td>
<td>603</td>
<td>956</td>
</tr>
<tr>
<td>Taluka Hospital Dokri, Larkana</td>
<td>1534</td>
<td>2270</td>
</tr>
<tr>
<td>Taluka Hospital Ghotki, Sukkur</td>
<td>271</td>
<td>1004</td>
</tr>
<tr>
<td>RHC Bachal Shah Miani, Sukkur</td>
<td>183</td>
<td>160</td>
</tr>
<tr>
<td>BHU Abad, Taluka Sukkur</td>
<td>8434</td>
<td>5893</td>
</tr>
<tr>
<td>Civil Hospital, Sukkur</td>
<td>921</td>
<td>1622</td>
</tr>
<tr>
<td>RHC Matiari, Hyderabad</td>
<td>2000</td>
<td></td>
</tr>
<tr>
<td>CDF Women's Hospital, Hyderabad</td>
<td>17611</td>
<td>18021</td>
</tr>
</tbody>
</table>

**Table 27: Gender disaggregation in allocation of hospital beds (N=14 facilities)**

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Male Beds</th>
<th>Female Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMC Sobhraj Maternity Home, Karachi</td>
<td>N/A</td>
<td>120</td>
</tr>
<tr>
<td>KMC Abbasi Shaheed Hospital, Karachi</td>
<td>828</td>
<td>107</td>
</tr>
</tbody>
</table>
An analysis of data available from the hospitals’ records mentioned above (Table 26), indicates that 1,656 female and 1,589 male patients attended the Outpatients Department per day. The percentage of beds allocated to female and male patients was 38.34 per cent and 61.65 per cent respectively (Table 27), reflecting gender disparity.

Table 28: Gender balance in staffing (filled posts of doctors) (N=14 facilities)

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Male Doctors</th>
<th>Female Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMC Sobhraj Maternity Home, Karachi</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>KMC Abbasi Shaheed Hospital, Karachi</td>
<td>N/A</td>
<td>29</td>
</tr>
<tr>
<td>Sindh Govt. Hospital, Liaquatabad, Karachi</td>
<td>N/A</td>
<td>17</td>
</tr>
<tr>
<td>Sindh Govt. Services Hospital, Karachi</td>
<td>N/A</td>
<td>10</td>
</tr>
<tr>
<td>Shaikh Zaid Women’s Hospital, Larkana</td>
<td>N/A</td>
<td>28</td>
</tr>
<tr>
<td>BHU Dhamra, Taluka Larkana</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Taluka Hospital Dokri, Larkana</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Taluka Hospital Ghotki, Sukkur</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>RHC Bachal Shah Miani, Sukkur</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>BHU Abad, Taluka Sukkur</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Civil Hospital, Sukkur</td>
<td>N/A</td>
<td>30</td>
</tr>
<tr>
<td>RHC Matiari, Hyderabad</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>CDF Women’s Hospital, Hyderabad</td>
<td>N/A</td>
<td>26</td>
</tr>
<tr>
<td>Liaquat Medical College Hospital, Hyderabad</td>
<td>N/A</td>
<td>75</td>
</tr>
</tbody>
</table>

The ratio of women to men doctors was five to one (Table 28). However, in many facilities records for men doctors were not available, therefore the exact figures could not be obtained. There also seems to be a tradition of gender-based division of labour, due to which all women filled up the posts of nurses, whereas 71.7 per cent of vaccinators were mostly men (Tables 29 and 30). Such practices are reflective of culturally-defined gender roles. Table 30 reflects the concept of gender based division of labour, where all women fill up the posts as nurses.

Table 29: Gender balance in staffing (filled posts of nurses) (N=14 facilities)

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Male Nurses</th>
<th>Female Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMC Sobhraj Maternity Home, Karachi</td>
<td>N/A</td>
<td>12</td>
</tr>
<tr>
<td>KMC Abbasi Shaheed Hospital, Karachi</td>
<td>N/A</td>
<td>22</td>
</tr>
<tr>
<td>Sindh Govt. Hospital, Liaquatabad, Karachi</td>
<td>N/A</td>
<td>6</td>
</tr>
<tr>
<td>Sindh Govt. Services Hospital, Karachi</td>
<td>N/A</td>
<td>5</td>
</tr>
<tr>
<td>Shaikh Zaid Women’s Hospital, Larkana</td>
<td>N/A</td>
<td>8</td>
</tr>
<tr>
<td>BHU Dhamra, Taluka Larkana</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Taluka Hospital Dokri, Larkana</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Taluka Hospital Ghotki, Sukkur</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>RHC Bachal Shah Miani, Sukkur</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>BHU Abad, Taluka Sukkur</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Civil Hospital, Sukkur</td>
<td>N/A</td>
<td>30</td>
</tr>
<tr>
<td>RHC Matiari, Hyderabad</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>CDF Women’s Hospital, Hyderabad</td>
<td>N/A</td>
<td>8</td>
</tr>
<tr>
<td>Liaquat Medical College Hospital, Hyderabad</td>
<td>N/A</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>120</td>
</tr>
</tbody>
</table>
Table 30: Gender balance in staffing (filled posts of vaccinators)  
(N=14 facilities)

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Male Vaccinators</th>
<th>Female Vaccinators</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMC Sobhraj Maternity Home, Karachi</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>KMC Abbasi Shaheed Hospital, Karachi</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sindh Govt. Hospital, Liaquatabad, Karachi</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Sindh Govt. Services Hospital, Karachi</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Shaikh Zaid Women's Hospital, Larkana</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>BHU Dhamra, Taluka Larkana</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Taluka Hospital Dokri, Larkana</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Taluka Hospital Ghotki, Sukkur</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>RHC Bachal Shah Miani, Sukkur</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>BHU Abad, Taluka Sukkur</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Civil Hospital, Sukkur</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>RHC Matiari, Hyderabad</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>CDF Women's Hospital, Hyderabad</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Liaquat Medical College Hospital, Hyderabad</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Women’s Perceptions, Women’s Voices

Analysis of the study’s main findings indicates that provision of health care for women is still at an early stage of development. While gender-sensitivity is being instituted, it is not yet fully incorporated. This section provides a review of responses from interviews with 14 women and offers insights into some of the sociological and traditional beliefs and values that indirectly influence women’s health. Information and analysis of these interviews should be interpreted with some reservation because the sample size is too small, and merely provides a pointer to the issues.

Cultural constraints and dominance faced by women result in their inability to make decisions on their own lives. This fact is illustrated in the case of Kulsoom, who was accompanied to the health centre by her mother-in-law in a serious condition in her ninth month of pregnancy and was advised to get treatment immediately. However, both women stated that they could not stay at the hospital without the permission of Kulsoom’s husband. The mother-in-law even added, “They will kill me.” Although the doctor continued to insist that they stayed in view of Kulsoom’s critical condition, they left when the doctor attended to other ward duties. While women have to generally give in to gender-biased practices, there are still opportunities for them to change gender dynamics at the household level. This is evident in the case of a woman interviewed at the Abbasi Shaheed Hospital in Karachi. Asked about eating habits in the household and whether the family ate together, she said that there was no difference in the diet of husband and wife. However, when her mother-in-law who accompanied her, left her briefly, the woman revealed, “At my in-laws, the better portion of food is always given to men, but don’t tell my mother-in-law that I told you this. My husband and I live separately, so we eat together and our diet is the same”.

Several women expressed that the available facilities were adequate as their basic requirements were met. However, health providers do not always provide counselling and consultation; in some cases, doctors used their own instruments and attended to patients. It was pointed out that staff members are not always empathetic towards women. During interviews with women attending the Outpatients Department of one centre, the behaviour of the nursing attendant (ayah) was harsh, abrupt and rude and some women complained to the senior nurse or doctor.

According to data gathered from interviews with women, we observed that women generally avoid going to doctors because their health problems are not taken seriously. There are many instances where inadequate attention is paid to women’s health till the condition became critical. Women too consider themselves healthy if they are able to continue doing their daily tasks. Pregnancy and delivery are seen as normal events and part of everyday life that do not require any special care or treatment. Women also expressed satisfaction with their nutritional intake if they were able to eat enough to remain mobile in the home and attend to daily household chores. Although their health parameters are low, most women felt they were in good health and obtained adequate food and nutrition.
The present system of community health workers appears to be providing a boost to home-based health care, as reflected in the improved health indicators (contraceptive prevalence rate increasing while total fertility rate declining). However, as cultural constraints on women’s health care access still prevail, many women tend to go to health centres only during emergencies. In addition, geographical distance and inadequate communication links also adds to travel costs in households that are already experiencing strains in household budgets given the state of the economy.

Information from Interviews with Fourteen Women

Sexuality and sexual relations
The conventional reproductive health indicators mainly reflect outcomes of women’s status within marriage such as sexual relationships with their husbands. In most cases, marriage, whether consensual, arranged or pressured into, is a woman’s most likely route to sexual activity. When women who were married in adolescence relate their sexual experiences, the general perception is that this is typically coercive. Researchers faced difficulties when interviewing women on sexual issues: both the interviewer and the respondent were uncomfortable when discussing marital sexual activity. Women are rarely asked by outsiders to comment on issues such as sexual behaviour and male-female relationships. However, women in this study have responded differently to this taboo issue. These responses speak of individual positive experiences: twelve of them said their husbands seek permission for sexual intercourse and also respect their wishes while the other two said their husbands exert power.

Domestic violence
Any act of violence that results in or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats such as coercion, whether occurring in public or private life, is gender based violence. This study reaffirms that obtaining data on domestic violence is a difficult undertaking. Silent experience of violence is evident from the fact that 11 out of 14 women stated that they were not victims of domestic violence while the hospital data suggests that domestic violence is quite prevalent. Reports by human rights groups indicate that every second woman in Pakistan is a victim of direct or indirect violence. Media reports also suggest a continuing rise in physical violence within the home, with a report from Karachi stating at least every third married woman in the city faced violence of one kind or another.

Right to choose a marriage partner
Key questions about women’s rights were not addressed in the main quantitative study because the present format of the reproductive health programme of the Ministry of Population Welfare and Ministry of Health does not include a rights-based perspective. The low status and lack of decision-making power of women are revealed from the following responses: Out of the 14 women, two married for love, five was married off in arranged marriages without their consent, while seven of them said their parents obtained their consent.

Gender dynamics and household expenses
Data from the interviews demonstrated the male bias in households. Seven out of 14 interviewees’ husbands gave their monthly salary for home and personal expenses, four out of 14 stated that their husbands kept their salaries to themselves. There was also evidence of mothers-in-law being custodians of sons’ salaries. The data also suggests that income-earning women have the discretion of using their money appropriately.

Perceptions of needs throughout the life cycle
Responses from 14 interviewees offer insights into key perceptions regarding needs. Good food emerged as an important need, as cited by eight of them. Three of them said good food, care and a clean environment were important needs while one said good food and life free of tension.

CONCLUSIONS

This survey has shown that almost all the health facilities studied have incorporated some of the components of the Reproductive Health Package. The strategy has contributed to the paradigm shift from family planning to reproductive health and enabled better reproductive health care for women. It is expected that the new health policy approved in June 2001 will further this process with ten specific areas of reform, including addressing inadequacies...
in primary and secondary health care provision and services; bridging nutritional gaps; and promoting greater equity with safe motherhood initiatives, improved referral linkages, emergency obstetrics care and expansion of training to develop a cadre of 100,000 community-based health workers by 2003 for providing basic services at household level; and increase in the total number of nurses from 23,000 to 33,000 by 2005. Institutional and bureaucratic constraints as well as deficiencies in human, material and financial resources hamper service delivery and need to be addressed.

Using the present Reproductive Health Package as a template for further progress in the reproductive health sector and with the inclusion of ICPD and Beijing recommendations for a rights perspective, efforts can be enhanced to improve women’s health. The present social system, with its overtones of tribal and feudal culture, frequently promotes severe gender disparities, and the virtual ‘owning’ of women’s bodies by men. The media frequently cover violence against women by men that result from women’s efforts to exercise some degree of personal decision-making. Policies further this disparity with insufficient attention to female education, resulting in disparate literacy ratios and inadequate health facilities for women. For example, it is estimated by workers that approximately 60 per cent of home-based deliveries are still attended by untrained dais or traditional birth attendants 4. Another example is the gender-biased requirement for the husband’s permission before a woman can have tubal ligation. However, other studies have also indicated the sensitive and nurturing role of some men. It is this aspect of gender relations that needs to be strengthened through gender sensitisation programmes. Men and women could contribute more to the improvement of women’s health if their involvement was actively sought.

Education programmes should not include school curriculum only but have awareness programmes for the public, particularly women, on human and legal rights, citizenship and civil liberties. Gender sensitisation and women’s empowerment programmes could include assertiveness and skill development for women. NGOs have frequently observed that enhanced awareness is itself an empowering process, enabling women to be more articulate and play a greater decision-making role in health matters. Improved management skills for health personnel will aid considerably in the management of the reproductive health sector. The inclusion of monitoring and evaluation indicators will improve efficient functioning of the present health programme. The private sector is already involved in health service delivery, expansion of family planning facilities, and treatment of RTIs, STDs, HIV/AIDS, and gynaecology and obstetrics care. The SMP programme itself includes expansion through private practitioners. In view of their contributory role, an advocacy strategy can be designed to promote women’s health with their active participation.

Available data for financial allocations for the health sector are not transparent and needs to be remedied, so that accurate budgetary estimates can be prepared. Similarly, more gender-disaggregated data, particularly at provincial level, would help in attaining the objective of gender equity. It appears that the present 0.7 per cent of the Gross National Product allocated for the health sector5 is inadequate for the planned expansion of health services. More resources are also required for action-based research, publicity and advocacy for improved reproductive health for women. Although the promotion of primary health care has in recent years been receiving more attention and funds, a significant proportion of limited resources are allocated for curative medical care. Prioritised allocation of resources, linked to stringent needs assessment in the health sector would help in improved prioritisation of resources.

**RECOMMENDATIONS**

Clearly, there is a need to address women’s reproductive health needs specifically instead of just focussing on demographic goals. The present reproductive health programme should include gender-sensitisation and the attainment of gender-equity as an integral and essential component. This could be achieved through various levels and ways:

**Policy**

- The collaboration between the Ministry of Health and Ministry of Population Welfare needs to be further strengthened to improve overall reproductive health service delivery. Involvement of both the above ministries and preferably also the Ministry of Women’s Development,
for introduction and promotion of gender concepts into the present reproductive health programme is essential. Gender-based barriers that have cultural roots should be addressed in this component as their perpetuation will hinder the availability of reproductive health care for women.

- Begin dialogue with policy makers to promote women's health and gender equality.
- Improve national coverage of reproductive health care on basis of the present reproductive health service package using the life cycle approach. This service package contains detailed guidelines to make comprehensive health cover a reality by 2005. Improved health of women and men could also help to reduce the presently high cost of medicines, as treatment of infections involves considerable expenditure for the public.
- In line with the ICPD+5 recommendations, the right to sexual and reproductive health requires access to services for all, based on a principle of social justice that does not discriminate against disadvantaged and marginalised groups; freedom from violence, discrimination and coercion; and the participation of communities and women's groups in the design and delivery of services.

There is need to develop and test indicators that reflect issues pertaining to gender.

**Advocacy**

- Elimination of violence against women (VAW) should be addressed as a specific human/women's rights issue in the health programme. This could include components such as studying the reasons or causes underlying cultural and social discrimination of women; training health personnel to detect gender-based violence and sexual abuse; promoting gender equality and equity; enhancing public awareness about VAW via publicity in print and audio visual media; street theatre. Addressing this subject as a special need for women should be considered in the existing reproductive health package.
- Encourage the involvement of activist groups in women's health education activities to promote improved decision-making by women.
- Initiate public education and activities through the media to enhance public understanding of reproductive health and gender-sensitivity via the media.

**Information Education Communication (IEC)**

- In the preparation and use of IEC materials, use of audio visual media and street theatre should be considered as the presently high rates of female illiteracy are a hindrance to awareness raising on various women's issues.
- To address unequal power relations within the household and the consequent gender imbalance and inequity, public IEC materials should be designed to increase awareness about gender issues of health providers (suggestions detailed above); promote and provide training for gender-sensitisation, with the aim of gradually reducing/eliminating gender disparities.
- IEC materials should be developed with a special focus on women's nutritional needs.
- Publish informative booklets with basic information about women's health.
- IEC materials should include information on sexuality, reproduction, contraception, STDs, infertility and gender roles, and provide information about sites for service delivery.

**Service Delivery**

- Improve the present system of distribution of supplies and equipment which does not meet the requirements of health personnel and women.
- Reduce gender disparities in staffing and hospital bed strength at health care centres;
- Establish and promote “Well Women Clinics”.
- Ensure that the initiative of enhancing training and deployment of community-based health workers is effectively implemented.
- Encourage women to attend health facilities and provide comprehensive health information to women.
• Encourage women to seek post-abortion care with widely publicised comprehensive information and follow-up.
• Encourage greater dialogue about contraception among women and men, through counselling by community-based health workers.
• As many reproductive health issues as possible should be dealt with and relevant facilities provided at the same facility or service outlet.

**Training Curriculum**

• Training curriculum for health personnel should include interpersonal skills development, to enable better and fruitful interaction with women during counselling and consultation.
• Training curricula for community-based health attendants should also stress the significance of nutrition for women.
• Inclusion of gender concepts into policies and curricula, especially human resource training institutions for doctors, nurses, paramedics, other health and social service providers.

**ACTIVITIES AND OUTCOMES**

• Focus group organised in 2000 to ascertain the views of women held in Hyderabad, Sindh, Pakistan.
• A paper was presented on the study findings on 26 October 2002 as part of a talk on “Women & Health” at the Department of Mass Communications, University of Sindh, Pakistan.

**REFERENCES**


**ABBREVIATIONS**

AIDS Acquired immunodeficiency syndrome
BHU Basic health unit
CBD Community-based distribution
CEDAW Convention on the Elimination of all forms of Discrimination against Women
CHW Community health workers
CPR Contraceptive prevalence rate
DDHS Divisional director of health services
DPW Department of Population Welfare
EOC Emergency obstetrics care
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>FPAP</td>
<td>Family Planning Association of Pakistan</td>
</tr>
<tr>
<td>HHH</td>
<td>Heads of household</td>
</tr>
<tr>
<td>HIMS</td>
<td>Health information management system</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immuno deficiency virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information education communication</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant mortality rate</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra-uterine device</td>
</tr>
<tr>
<td>KMC</td>
<td>Karachi Metropolitan Corporation</td>
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<tr>
<td>LHW</td>
<td>Lady health worker</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal mortality rate</td>
</tr>
<tr>
<td>MO</td>
<td>Medical officer</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoPW</td>
<td>Ministry of Population Welfare</td>
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<tr>
<td>MoWD</td>
<td>Ministry of Women’s Development</td>
</tr>
<tr>
<td>MS</td>
<td>Medical superintendent</td>
</tr>
<tr>
<td>MSS</td>
<td>Marie Stopes Society</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>NIPS</td>
<td>National Institute of Population Studies</td>
</tr>
<tr>
<td>NVDs</td>
<td>Normal vaginal deliveries</td>
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<tr>
<td>OPD</td>
<td>Out-patient department</td>
</tr>
<tr>
<td>OPP</td>
<td>Orangi Pilot Project</td>
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<tr>
<td>PDHS</td>
<td>Pakistan Demographic and Health Survey</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>PoA</td>
<td>Programme of Action</td>
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<tr>
<td>RH</td>
<td>Reproductive health</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural health centre</td>
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<tr>
<td>RR</td>
<td>Reproductive rights</td>
</tr>
<tr>
<td>RTIs</td>
<td>Reproductive tract infections</td>
</tr>
<tr>
<td>SAP</td>
<td>Social Action Programme</td>
</tr>
<tr>
<td>SR</td>
<td>Sexual rights</td>
</tr>
<tr>
<td>STDs</td>
<td>Sexually transmitted diseases</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
</tr>
<tr>
<td>TFR</td>
<td>Total fertility rate</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund For Population Activities</td>
</tr>
<tr>
<td>VAW</td>
<td>Violence against women</td>
</tr>
<tr>
<td>VBFPWs</td>
<td>Village-based family planning workers</td>
</tr>
<tr>
<td>WMO</td>
<td>Women’s medical officer</td>
</tr>
</tbody>
</table>

**NOTES**

3. ARROW Resource Kit, Tool No. 5.
5. Name changed to protect identity.
7. Personal communication with Imtiaz Kamal from the National Committee on Maternal and Child Health.
Overall analysis of the research findings and recommendations

Rashidah Abdullah and Monica Jasis

INTRODUCTION: CONCEPTUAL FRAMEWORK

All studies involved in this project, although based on the same reference of ideas, resulted in distinct case studies. In this chapter we do a comparative analysis of results, considering all country case studies, in order to make a useful contribution and to learn from the case studies towards the achievement of the project objectives.

The research objectives, the research questions, the conceptual matrix, and the definitions (see Chapter 1, page 6) set the foundation for outlining a conceptual framework for the case studies. Each research team interpreted the concepts for their enquiry and developed specific indicators using the tools provided. When the first drafts of the research reports were completed, the various indicators used to assess access to quality of care including gender-sensitivity and women-centredness were collectively compared to formulate a framework of indicators. The framework of indicators helped in the comparative analysis of the various findings in different countries. This tool can also be adapted and used for the assessment of quality gender-sensitive health care by both governments and non-governmental organisations (NGOs) (see Tool Chapter for framework).

A diagrammatic framework to present the main concerns and research questions was also prepared towards the end of the research as a tool to assist in the analysis (see following page ). This diagram explains the research focus on women, what they need, want, and feel a right to in terms of the specific health services addressed, particularly in relation to their access to affordable, quality and gender-sensitive services, as well as the perceptions of barriers that women and health service providers face in meeting the desired needs. Positive outcomes for women such as satisfaction with services, resolution of health problems and greater autonomy and confidence (aspects
of empowerment) were also included. Although each case study did not focus on all aspects of the enlarged conceptual framework or employ all indicators, both tools were used for the comparative analysis of findings with the anticipation that this may lead to greater insight and more useful overall recommendations and ideas for advocacy.

**FINDINGS**

The comparative findings of this research provide insights into women’s and service providers’ perceptions of access to health care and can be used to improve health systems and services for women. They are presented in relation to the research questions and the framework of variables and indicators used for the comparative framework of analysis (see tool chapter). The analysis is based on the full final case study reports submitted to ARROW which have been shortened for this publication.

**What Do Poor Women Want, Need and Feel a Right To in Terms of Their Access to Comprehensive, Quality Health Care Which is Gender-sensitive?**

- **Cost of health services**

  Poor women in Bangladesh, China, Pakistan and the Philippines spoke of their difficulties and anxieties in raising sufficient funds to directly pay for services and medication and indirectly for transportation costs. Bangladeshi women worry about the cost of childbirth services and prefer cheaper home delivery, even though the NGO-established BRAC (Bangladesh Rural Advancement Committee) health centre (BHC) uses a sliding scale for fees. Twenty per cent of Chinese women interviewed found health service costs expensive, especially migrant women from other provinces. In both Pakistan and the Philippines, women said public transport and ambulance costs were significant barriers to accessing health care. Many Pakistani women had to be accompanied to the hospital by their husband or in-laws (or both) due to gender mobility norms for women which meant a higher transportation cost. Although the Philippines government hospital provided free treatment, women had to purchase medication, blood for transfusions and other supplies. Doctors said they sometimes gave money to patients to purchase blood etc.
• **Respect to women as persons**
Women were able to clearly articulate what they did not like and what they liked in their interactions with health providers. The two NGO health services in Bangladesh (BRAC) and Malaysia (Kelantan Family Planning Association) had a higher rating than the government or private sector health services. Women said there was only minimal rudeness in the BRAC health centre, whereas in one large government centre in the Philippines, women complained of frequent impersonal treatment, scolding and arrogant and insensitive doctors.

• **Care including emotional support to clients**
Women in the Bangladesh, Malaysian and Philippines case studies commented on the extent of the care and support shown by staff. Care and support included expressions of reassurance, understanding and kindness directed towards allaying their fears and concerns. These responses were highly valued by the women. BRAC staff were perceived to be caring or making an effort to meet women’s needs (because they cared). The Kelantan Family Planning Association (KFPA) scored highly for the warmth and close relationship staff had with their clients, always monitoring the women and encouraging them to have their check-ups on time. Good relations between providers and women were identified as a reason to use services run by both NGOs. This contrasted with the Philippines government hospital in which women during childbirth were on their own and the women felt the staff did not care about their suffering.

• **Privacy and confidentiality**
The women themselves did not articulate this service aspect as a need or right, but researcher’s observations in three case studies noted violations to privacy standards for childbirth and medical consultations. In Bangladesh and the Philippines, privacy violations in childbirth services were observed. In China, several clients were seen by the provider simultaneously. This lack of respect for their privacy appeared to make the women uncomfortable and affected their wellbeing.

• **Power of asking questions, giving feedback and registering complaints**
In four of the case studies, women said they rarely asked their providers questions. In China, women were afraid to interrupt busy staff. Bangladesh women expressed feelings of intimidation in their interaction with providers and were too scared to voice their feelings. In the Philippines study, women wanted to express complaints but said they were afraid of possible negative consequences. They also did not feel entitled to ask questions. In the case study of KFPA, women were encouraged to question and the IPPF (International Planned Parenthood Association) Client’s Charter of Rights was displayed but providers said that women were often uninterested and had no time to ask questions.

• **Decision-making on reproductive rights: the extent to which women participate equally with the provider in decision-making on contraceptive methods, childbirth position, caesarean birth, ligation, abortion etc.**
In Bangladesh, women expressed a strong preference to squat or kneel when giving birth as they did at home, however women didn’t have this choice as BRAC health centres conformed to the biomedical model of giving birth lying down, even though squatting or kneeling was known to have no adverse consequences. In Bangladesh as well as in the Philippines, it was observed that there were deficiencies in the informed consent and choice processes regarding medical interventions. In Malaysia, the researcher found that women could relate to the right to informed choice, decision-making on childbearing and to access to services, but could not conceptualise the right to be listened to one’s own experience. Women clients also could not understand how gender relations have an impact on sexual and reproductive rights.

• **Comprehensive range of services**
BRAC clients wanted emergency and birth complications to be dealt with also at the BRAC health centre, rather than have women be referred to the government hospital. For Chinese women in Yunnan, sexually transmitted disease (STD) services within government maternal and child health (MCH) services were lacking. Sri Lankan factory workers wanted an improvement in the range of services available to them in the factory medical centre itself.

• **Women’s awareness of health rights**
Only the Malaysian study probed women’s awareness of their rights to quality health services. Even in this context, women were not able to directly express
their perceived entitlements, although they were able to agree or disagree with relevant statements. For example, women believed in their right to be treated with respect and not to be abused by health providers, as sometimes happened in Malaysian government hospitals. Some women believed men (namely, their husbands) also had the right to be consulted by their wives on decisions regarding reproduction.

The Extent of Gender-Sensitivity of Services

- **Availability of women providers for medical examination and childbirth etc. (if women express such a preference).**

  Not all researchers asked women what they wanted or preferred in terms of the gender of the health provider. Women service providers assisted with all deliveries in the BRAC health centre (unless there were complications) which was what Bangladesh women said they wanted. Although women in the KFPA expressed preference for women doctors, they were not available as KFPA lacked the resources to fulfill this need. Thus, while KFPA management and staff believed in the principle of gender-sensitive services, in actual practice what women wanted most could not be given.

- **Prevalence of gender imbalance in health services**

  Gender imbalance was present not just in the woman-provider relationship, but also within some hierarchical medical systems. For example, in Bangladesh, while most paramedics were female, doctors were male. Males were not allowed into the birthing room at the BRAC health centre. In Pakistan, researchers report gender imbalance in staffing and allocation of hospital beds creating problems for service delivery.

- **Gender bias or gender stereotypes regarding spousal consent for ligation, abortion etc.**

  In both the Philippines and Pakistan case studies, the husband’s consent was required for a woman's tubal ligation in addition to a woman's own consent. In the Philippines hospital, consent by the husband for abortion was also required and for emergency circumstances, only the husband's consent was required. In Pakistan, the husband had also to agree to the woman seeking treatment or staying in hospital.

- **Provision of information and services on gender issues such as violence against women (VAW), sexual rights and relations, contraceptive responsibility, gender rights and negotiation in decision-making**

  Only the KFPA had proactively included information and services to address common and related gender issues such as violence against women, sexual rights, gender and contraceptive choice etc. This is evidence of the insensitivity to the existence of critical gender issues related to unequal power relations which often prevent women from accessing care and also the difficulty in knowing how to practically address gender issues in health services. These issues have to be openly talked about and confronted in reproductive health services in order for reproductive health to be improved. Although KFPA at policy level had expressed a commitment to gender equality, it was not yet able to address gender issues at the service level in reproductive health information and education. The health care system, in following and enforcing these procedures, is reinforcing male dominance and women's subordination in relationships. It is thus not sensitive to the need to promote gender-equality and challenge stereotypes and is gender biased.

- **Involvement of male partners as expressed by women**

  Generally, it was found that health services did not have a programme policy on men's role in supporting women's reproductive health. In the China case study, women expressed that they wanted their husbands to be involved in RTI treatment as without their husband's involvement, their own treatment would not be effective. However, health providers had not yet responded to this need. In some situations, men gave practical support to their wives on their own initiative, such as collecting contraceptives at the Malaysian KFPA clinic or accompanying them to the clinic as in the Philippines, Pakistan and China.

- **Extent to which the services provided reinforced unequal gender roles and gender-stereotyped behaviour.**

  At the BRAC health centre, husbands were not allowed in the delivery room. Only female relatives could provide such support as is the cultural and gender norm associated with childbirth in Bangladesh. This procedure is thus a reinforcement of the gender stereotype/expectations of men and women’s relations. Other case studies did not report on this concern.
Adequacy and Sufficiency of Health Information Given

Women did not comment on this, but researchers observed that in five of the case studies, inadequate health information was provided to women. At the BRAC health centre, information of the progress of childbirth provided to both the woman and her family was not given or recognised as a right. Chinese women were given inadequate information on reproductive tract infections (RTIs), self-care practices and referral in the clinics and poor information about RTI services. Family planning and abortion information in the Philippines’ government hospital was assessed as poor in both content and the timeliness.

Health consultations in Pakistan and China were observed to be very short, thus not allowing sufficient time for health information to be given to women clients. In Malaysia, women clients were particularly concerned about the permissibility of certain contraceptives in accordance with Islam. Many of them were fearful of side effects and believed in a number of related myths, as these concerns had not been addressed in health information education. This was assessed as due to the inadequacy and insensitivity of health workers.

Discussion on What Women Want, Need and Feel A Right To

From the above analysis, we can say that while poor women were able to articulate their needs and wants to researchers, their understanding and expression of their health rights were very limited. On the top of their list was the need to be respected and cared for by service providers and not be abused or scolded. Women in childbirth appreciated emotional support and understanding. Women in most of the studies however, did not dare to express their needs, to ask questions, or give feedback and were intimidated by and fearful of staff due to possible negative consequences. The exception was the KFPA service in which women felt supported and cared for by the staff.

The other changes women wanted in health services besides more respect and care were less costly services, closer services, choice of birth position, women service providers for medical examination/childbirth, more involvement of their husbands in RTI treatment and a wider range of services available in one health centre.

Researchers also observed other needs not articulated directly by the women and related to the quality of services. These were more adequate information provision and better privacy of facilities. On gender issues, researchers noted gender bias regarding spousal consent for ligation, abortion and hospital treatment in the countries. Gender stereotypes were also practised at the BRAC health centre where men were not allowed in the delivery room due to cultural inappropriateness. None of the services, either primary health or reproductive health, had direct proactive information and services related to relevant gender issues such as sexuality, violence, contraception etc.

None of the health services could be considered fully gender-sensitive in their operations and thus a lack of gender-sensitivity was common for most of the case studies. However, on a continuum, some services were gender neutral such as the KFPA as there was no obvious gender bias present whereas some services such as the Philippines had a definite gender bias regarding husband’s consent for medical procedures.

However, there are some health systems that have advanced in adopting a reproductive health approach, such as the services studied in Pakistan, Malaysia and Bangladesh. The research in Bangladesh found that health providers were not aware of all issues related to women in their services. In Sri Lanka, the factory medical services did not incorporate the reproductive health concept and were not sensitive to gender needs. In Malaysia, health providers didn't understand completely the relationship between gender roles and relations, morbidity, women's rights and women's needs. Regarding violence against women (VAW) in Pakistan, Philippines and Malaysia, it was found that providers were aware of the problem.

The Main Barriers in Women's Access to Gender-Sensitive Quality Health Care

•   Access

Distance to health services
Distance was a major barrier in women’s access to services except in Malaysia. In Bangladesh, distance becomes a barrier due to poor availability and high cost of transportation to BRAC health centre especially in emergencies.
Women in the Philippines spoke of the long, difficult and costly travel required from remote rural areas to the urban hospital. Pakistani women also mentioned distance as a major constraint to utilisation of health services. In China, women who most needed RTI services lived very far away from health centres.

Access to health information prior to and during services
Inadequate access to health information was found in the China case study, where women had more information through the mass media instead of the health centres. Most Chinese women were not aware of the availability of RTI services at primary health centres or the need for RTI screening. In the Philippines hospital, it was found that reproductive health services provided insufficient information on family planning, reproductive health for post-partum women or post-abortion care to meet women’s needs. In Bangladesh, researchers found that women had many beliefs and misinformation about hospital care as well as the use of medical services. They related medical intervention to illness or when “something went wrong” and this belief played a negative effect in childbirth as they did not seek hospital care. In addition, lack of explanation to women about the need for a process of medical procedures in childbirth was clearly found to be a problem. In Pakistan, rural women had less access to health information and knowledge, as well as to available resources. Lack of health information released by doctors to women users was reported in all studies.

Traditional beliefs
Traditional beliefs and cultural differences between health providers and women were observed to be obstacles to access health care in many countries. In Bangladesh, women felt more comfortable with traditional birth attendants than trained service providers because they lived in the same area and sometimes they were also the women’s friends. Researchers indicated that this horizontal relationship encourages women to actively participate during childbirth. Women felt that doctors were not close to their culture. Health providers at the hospital treated women in a very authoritative way. In the Philippines, researchers found that doctors criticised women for what they called “their unreasonable adherence to supernatural beliefs”. Doctors at the hospital also criticised women for seeking abortions. In Malaysia, researchers found that interpretations of traditional Islamic beliefs were still obstacles for the understanding of modern contraception, therefore acting as a barrier for the use of contraceptive methods by women and for the promotion of those methods by health providers.

- Gender factors
The Pakistan and Bangladesh case studies found unequal gender norms to significantly influence women's health-seeking behaviour and access to health centre services. Fifty-one per cent of the Pakistani women interviewed were not allowed to go outside the house to the health centre alone and only six per cent had ever visited a health centre on their own. Twenty-two per cent were accompanied by husbands to the health service centre. Bangladesh women did not feel entitled to make independent decisions about seeking health care if this extended beyond the household. The decision on when and whether to go to the hospital for a Bangladesh woman in labour was made by the husband or in-laws. However, researchers found that women who were economically better off had more decision-making power generally and that female family members as a group were influential. Women themselves accepted these unequal gender norms.

- Health care system
Cost of services
Prohibitive cost of services was an issue for women in five of the six case studies as outlined in the first section. It was both an access factor to be considered by women before deciding to seek the services as well as a factor in accessing treatment once within the health service (for example, purchase of medication and blood). Doctors in the Philippines also recognised cost as a serious problem and some said they even gave their own money to patients to make purchases of blood and medication. Only in the case of KFPA, the lower cost of reproductive health services compared to private sector services of doctors, and was a positive factor to encourage women to seek services at KFPA.

Health service budget
Doctors and nurses in the Philippines hospital spoke of the inadequate budget of the hospital and the whole health sector to provide the health services people
needed. The KFPA also acknowledged lack of resources to employ a full-time woman doctor even though the management had made a policy commitment to meet the gender-sensitive needs of women clients.

Heavy workloads of staff
Heavy workloads of doctors and nurses were identified as a problem by health providers themselves. Related to an inadequate health service budget, providers spoke of their heavy workloads, particularly in the childbirth service at the BRAC health centre in Bangladesh and in the Philippines hospital. BRAC paramedics explained how they worked 14-hour days or more due to staff shortages and they were exhausted and frustrated. In the Philippines hospital, stressful 24-hour duty periods were common as a number of women often gave birth simultaneously. In the Sri Lankan industrial health facility for women workers and the KFPA, workloads were also reported to be heavy.

Limited decision-making power of providers
Health service providers in the Philippines and Bangladesh, especially nursing assistants said they had little influence over health service management decisions related to workloads and budgets due to the hierarchical structure of the organisations.

Insufficient incentives
BRAC providers in Bangladesh commented that there were no incentives from management given to staff who demonstrated nurturing and caring attitudes to women clients.

Inadequate provider training curriculum and training courses
All of the services and organisations studied had no orientation or training on gender, women's health and human rights for providers. The Bangladesh researchers noted that BRAC training curriculum did not include the concept of clients’ rights. In the Philippines, researchers found that there was nothing in the medical and nursing school curriculum on interpersonal skills and how to be non-judgemental of clients. There were also no socio-cultural and economic aspects of health care to facilitate a clearer understanding of determinants that influenced health-seeking behaviour. Some providers in the Sri Lanka study had received no training courses of any kind in the last five years. The Malaysian KFPA did not have a local budget for staff training but relied on centralised training, hence no local training of any kind to meet specific needs had been done.

Lack of empathy with women and the poor
Researchers in Bangladesh and the Philippines commented that providers were unable to adequately empathise with the concerns and fears of women. In Bangladesh, this was despite BRAC staff themselves coming from poor rural areas. In the Philippines hospital, some staff were moralistic in their interactions with women who had abortions. Researchers noted the lack of sensitivity of medical staff on the issue of women inducing abortions due to poverty-related situations.

Biomedical concept of women's health
The BRAC approach to women’s health reduced women to passive objects as women were not seen as participants in health services. The resulting hierarchy and inequity in client-provider relationships was therefore built into the health care system.

Perception of low quality of health services
Chinese women perceived that government primary health services were of poor quality and this kept them away from seeking services unless it was really necessary. Bangladesh women had the same view of government health services and thus preferred BRAC health centre services if they could afford them. Researchers observed long waiting periods for women for medical consultations in Sri Lanka and the Philippines.

Evaluating Health Service Outcomes for Women

- **Extent of satisfaction with quality of service**
  In none of the health services studied were women completely satisfied. What women in all the case studies were most dissatisfied with was the way they were treated by service providers in terms of insufficient respect and care. Only women in the Malaysian KFPA were fully satisfied with this service aspect; their only dissatisfaction was that KFPA lacked women doctors. Women in China and Bangladesh were also less satisfied when services they wanted
were not available in the health centre as part of a comprehensive package, and they had to seek these services elsewhere.

• Extent health problems and needs were resolved
Researchers found that there were many health needs of women which were not met by the services, although women themselves could not always articulate these unmet needs. Generally, these were health information and needs which would assist women to understand and prevent problems, take better self care of their health, and address gender and other socio-cultural barriers affecting their health or health-seeking behaviour. Although women obtained the medical services which they sought (assisted childbirth, RTI treatment, contraception, etc.), they often did not receive comprehensive health information to protect and promote their health in the future and deal with the root of some of their health problems or needs. For example, Chinese women came repeatedly for RTI treatment but were often not informed that they could be re-infected by their husbands who also needed simultaneous treatment. Malaysian women received contraceptives but a number still had uncertainties and anxieties about contraceptive side effects which were likely to affect their future contraceptive use.

• Extent women were empowered as an outcome of the service
Women's empowerment was seen in relation to two dimensions, namely an increase in personal confidence, self-esteem and the capacity to decide and then act to fulfil one’s needs (psychological); and an increase in the ability to decide, assert and realise one's autonomy as a woman in relation to others and to men.

In none of the six health services studied was there evidence that women felt more personally empowered as an outcome of the service received or empowered to assert their needs during the service. In fact, the general finding was that women were disempowered in varying degrees as an outcome of the service, with the exception of only the KFPA. Women in China, the Philippines and Bangladesh were intimidated by health providers who often scolded or showed no care and concern for them. Instead of asking questions and expressing their needs and preferences, clients acted passively as expected, fearful of the negative consequences in the hierarchical provider-client relationship. This subordination of women in the health service could have reinforced women's secondary position in society and the family. As little time was spent on health information and self care, women did not have the opportunity to increase their awareness and knowledge of how to better address their health problems themselves. Critical information as a source of control of one's body and life was therefore unavailable to the women. Decisions on childbirth positions, ligation, treatment, abortion etc. were made by the providers or in consultation with the husband.

Women’s capacity to make decisions on their own health care did not increase as an outcome of interaction with the health care system. Similarly, as all services did not fully acknowledge, explore and address problems of gender inequality, gender power relations and violence against women in relation to women's health, women did not gain insight or confidence about how to address any difficulties they had with their husbands or partners. In the KFPA, although women were treated well by providers and were thus likely to have an increased sense of wellbeing as an outcome of the service, the service did not provide them with an increase in knowledge about their bodies, their rights as women and clients, and equal gender relations. They thus cannot be said to be empowered as an outcome of the services received.

Health services could be categorised in relation to the women’s empowerment variable as either having further disempowered women, reinforced women's status (neutral or no change) or increased women's empowerment.

An increase in women's capacity to make their own decisions to improve their health and wellbeing during the service and afterwards, is a critical outcome to be aimed for by health services. If women are provided with sufficient information and the opportunity to discuss their problems and are then encouraged and respected to make an informed choice when they are in the health centre, then there is more likelihood of women deciding on other aspects related to their health outside the health service. These aspects include negotiating condom use for safe sex, seeking hospital treatment in emergencies, and resisting unsafe sexual practices from partners.
Changes to Health Services as a Result of the Action Component

A number of positive outcomes resulted from activities aimed for change based on the findings and implemented during and at the end of the research by the researchers. These outcomes emerged after workshops and meetings organised for management and health service providers. The Sri Lankan and Malaysian action research produced the most positive outcomes as more activities were implemented.

Bangladesh
- Comprehensive obstetrics care at the BRAC health centre is now starting in stages.
- A feasible sterilisation procedure has been adopted at the BRAC health centre in order for caesarean operations to be carried out.
- Despite budget constraints, funds were made available to provide comprehensive obstetrics care to poor rural women after appealing to programme heads of BRAC.
- BRAC health centre providers received further training on midwifery and hands-on training in the operation theatre.
- A female physician was hired for the BRAC health centre, ensuring that the paraprofessionals at the centre are all women.
- There will be budgets in the new BRAC programme for the poor to ensure that poor women receive better access to maternity care.
- Workshops on gender-sensitivity have been organised for health providers after a training module had been developed incorporating the findings.
- Authors have had their research and findings used in two publications, *Reproductive Health Matters* (2000) and *Discovering Birthing Care* (2000).

China
- It was the first time for the researchers to directly share research findings with both policy makers, service providers and the women clients at different settings in a participatory manner where each stakeholder had equal opportunity to share, discuss and dispute.
- The workshop with the policy makers and service providers allowed two different sectors – the maternal and child health (MCH) and family planning – to come together to discuss RTI issues as there were not many opportunities for them to come together previously.
- The participants from the family planning service expressed their interest to have more guidance and technical support from the research team and Yunnan Reproductive Health Association in the future. Two projects were developed in collaboration with the research team and two family planning service sectors to improve RTI services after the research findings’ workshop.
- Commitment to reprint more information education communication (IEC) materials on RTIs developed by the research team from one of the family planning service stations.
- A meeting organised with women who were clients of a family planning service station, in which women were able to raise questions on their health concerns, served to fill the gaps in information that women faced with regard to RTIs.

Malaysia
- A strategic planning workshop developed KFPA action plans to address issues such as the use of traditional methods, family planning and Islam and misconceptions on contraception.
- An orientation on gender concepts and gender dynamics/relations between men and women for staff built confidence to allay fears of certain contraceptives from an Islamic perspective.
- A public education booklet on Islam and contraception was produced in collaboration with Sisters in Islam, a non-governmental organisation, following a workshop with KFPA staff who contributed their views and perceptions on women’s reproductive health. This is the first such booklet on this topic in Malaysia and was widely distributed nationally to both service providers and clients.
- The first workshop on SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of KFPA services and organisation, both at the work and individual levels, assisted to see how personal life and work goals matched with the organisational goals and to bring
out differences in perceptions between providers and the management, particularly the Executive Board.

- A half-day seminar on “Men against violence in families” to look at violence in families from the Islamic perspective was held since violence against women was a concern identified by the staff of KFPA and allied NGOs in the state. This was the first seminar in the Kelantan state targeting men specifically.
- As a follow-up to the half-day seminar, KFPA called a meeting with women NGOs in the state to discuss the directions to be taken by women NGOs in relation to the issues of violence. The result was a workshop on building the capacity of women NGOs in management skills to strengthen and professionalise their organisations. This was a first for women NGOs in Kelantan to receive such training.

Philippines

- Hospital management has installed a suggestion box for clients for the first time.
- The establishment of an area for watchers at the birthing centre at the hospital.
- Findings from the research were incorporated into training sessions on gender-sensitive health care and ethics of care for health providers at the hospital.
- Doctors’ deeper involvement in the women crisis unit on violence against women at the hospital.
- More visible participation of doctors in advocacy and capacity-building on issues related to women’s health.

Sri Lanka

- The Provincial Director of Health Services (PDHS) consented to release a doctor every three months to visit the factories with transportation provided by the factory management.
- Priority was given to FTZ employees to visit the nearby occupational health centre (OHP) by providing them with a gate pass and a medical record book. Service hours were extended until 6:00 p.m. from the normal 4:00 p.m.
- Nurses attended workshops to learn to provide effective care for stress-related complaints for headache, backache, and tiredness.
- Doctors underwent stress management techniques demonstration and were informed of counselling services to facilitate referrals.
- A Medical Officer of Health (MOH) agreed to visit factories once a month to give a short talk on the public address system on important health topics.
- The awareness of gender-sensitivity in health care was raised through informal discussions with relevant stakeholders: the Board of Investment officials, service providers, women workers, supervisors and management.

SIGNIFICANCE OF THE RESEARCH AND LESSONS LEARNED

How do the findings and lessons learned of this project contribute to current conceptual issues being discussed on health service design and implementation for women?

Importance/Value of Qualitative Health Research

In all country and health service contexts, the qualitative research methodology of in-depth interviews, focus group discussions and observations has been able to produce new information on women and providers’ views on access to quality and gender-sensitive health care. Such information is critical for the formulation of recommendations and interventions to improve health services for women. For all health services evaluated, this was the first time that women and providers were consulted which demonstrates the need to understand and promote widely the value of qualitative health research with women clients and providers.

Research Tools for Evaluating the Women-Centred Focus and Gender-Sensitive Approach to Health Care

At the outset of the research, few tools were identified through a global information search which could be adapted for use by researchers in evaluating health services. Whilst conventional quality of care indicators were available, these did not include the dimensions of women’s needs and rights or gender-
Sensitive variables. It is essential that more of such tools are developed, tested and promoted.

**Importance of Action Research**

The great potential for research to be a positive catalyst for change during the research process itself and at the end of the research has been demonstrated by this project. The planned activities of workshops and meetings for health service providers and management to participate in planning the research and acting quickly on key findings have resulted in a number of positive outcomes to immediately improve services for women.

**Conceptual Clarity of Gender-Sensitivity**

The concept of gender-sensitivity of the 1990s, endorsed as an important approach to health service delivery for women by the Cairo and Beijing Conference is not yet clearly understood by health service systems, by health researchers or by women themselves. Conceptual and operational definitions and frameworks which do exist vary in their value base and extent of their conceptual clarity. The World Health Organisation (WHO) needs to work with women NGOs and agree on the most useful definitions and then widely disseminate, promote and utilise the concepts for orientation, training and monitoring of health services. Ministries of health, and health NGOs, need to be guided by these standard conceptual and operational frameworks.

**Expanding the Quality of Care Concept to Add Women’s Rights, Gender and Empowerment**

The conventional quality of care framework of Judith Bruce needs to be enlarged to include women-centred and gender-sensitive dimensions. The recent work of the *Latin American and Caribbean Women’s Health Network (LACWHN)* and the *IPPF (International Planned Parenthood Federation)* Western Hemisphere’s *Manual for Evaluating Quality of Care from a Gender Perspective* in extending this framework has been very important. The comparative analytical framework of this project is an example of such an enlargement. Women’s needs and rights (women-centred) as well as gender-based variables are included in the framework as an important part of quality of care (see Tool Chapter). This enlarged framework needs to be used widely by the health system to plan, implement and evaluate the health service curriculum, medical training, health service planning, implementation and evaluation, and health research.

An argument can be made that a health service for women cannot be considered a quality service unless it addresses women’s needs, rights, experiences and perspectives and aims to increase women’s empowerment as an outcome. A gender-sensitive service necessarily focuses on women’s needs and addresses gender inequalities, biases and stereotypes. A gender-sensitive health service can also assist in women’s empowerment by helping women to gain information and perspectives and provide or allow experiences which do not reinforce gender norms or biases. How adequate the quality of the health service is for women, needs to be evaluated according to the outcomes for women evaluated by women themselves. The diagram on page 118 (*Conceptual Framework*) which draws on Matamala’s analysis and the work of LACWHN sees these outcomes as:

- extent of women’s satisfaction with services;
- extent women’s health problems/needs are resolved; and
- extent women are empowered to decide on their health needs and overcome gender-related barriers.

**Affordability and Quality of Health Services**

In a number of government and non-governmental organisation settings, the cost of transportation to the health centre and the actual cost of services and treatment, was a huge burden for poor women and their families. More regular monitoring and research need to be done both at a local service level and nationally to determine if services are becoming more costly, whether the numbers of providers are declining, has overall service quality declined and have local service and national budgets declined.

Overall, the impact of changes in health financing as part of health sector reform linked to globalisation needs to be known. A national commitment and plan needs to be implemented to increase the health budget and make available more resources for the health system for personnel, medication and information.
Evaluation of Women-Centred and Gender-Sensitive Health Service Outcomes for Women

Health service outcomes to measure the extent to which women were able to access quality, gender-sensitive health services to meet their needs, have to be more clearly defined as variables and indicators in order to better evaluate women-centred health services. In order for the health system to find where interventions are needed to improve service quality, evaluation should be part of a comprehensive women-centred programme. Evaluation needs to be made on processes, not just outcomes. For this matter, assessments based on qualitative techniques are extremely useful. The variables ‘women’s satisfaction with services’ and ‘extent of women’s empowerment’ need to be added to biomedical indicators such as safe childbirth, effective RTI treatment, etc. These new variables highlight the difference between the conventional quality of care framework for which clients’ satisfaction is a progressive new variable and quality of care with a rights and gender dimension. Quality of care cannot be measured through satisfaction alone as it is also related to the outcome of services affecting the control of women’s resources (such as information), and their decision-making powers with men.

Concept of Women-Centred Health Services

The concept or approach of women-centred health services has been promoted by ARROW since the beginning of its programme as a useful approach which focuses on women’s needs and experiences and is different from a gender-sensitive approach. ARROW has produced two resource kit tools explaining the women-centred concept as different from gender-sensitive. The concept which has also been promoted by Reproductive Health Matters Journal and other women’s health NGOs, is included as a concept in the Beijing Platform for Action and most recently in the World Health Organisation’s 2002 project on “Women Friendly Health Services”.

This project has found that it is possible to operationalise the concept concretely into a framework of indicators which allows measurement of health services and which can also guide service design, implementation and research (see Tool Chapter for the framework). In this framework, the concept has been extended to also include women’s rights to accessible, affordable, quality and gender-sensitive health services. An added variable of women’s empowerment as an outcome or goal of women’s health services has further enlarged the approach.

A tricky theoretical question asked by researchers is about the relationship of the women-centred concept to the gender-sensitive approach. How can they be understood together for clarity? It would appear in order for a health service to be women-centred, it would also have to be gender-sensitive. That is, being aware of and addressing issues affecting women’s access to and experience of services through a gender analysis of the power relationship between men and women. Gender-related needs are a critical dimension of women’s needs, rights and experiences.

Overall Comments

When evaluating health services for women, health planners, managers, consultants and researchers need to begin with a women-centred approach and consider the following:

• What are women’s needs, both their health needs related to their biology as well as the gender needs socially constructed by their relationship with men which are barriers to their health-seeking behaviour and health outcomes?

• What are women’s rights to health services? What have the United Nations Conferences and Conventions agreed that women have the right to expect and receive from health services? What do women themselves understand as their rights? Rights have been articulated usually in terms of availability of services, access to comprehensive, affordable, quality and gender-sensitive services.

• How can women clients best participate in sharing their needs, experiences and perspectives in the design, implementation and evaluation of health services?

• How can health service implementation ensure that women’s rights and needs are respected and that the services actually increase
their wellbeing and status, instead of further disempowering women or reinforcing their subordinate status?

Within this broad framework, gender-sensitivity is an important dimension which addresses a critical component of women’s needs to have a more equal/equitable relationship with men which does not act as a barrier to their access to health services nor impact negatively on their health or wellbeing. Finally, quality of care for women needs to be understood as meeting women’s needs and rights, including their perspectives and experiences as well as addressing gender issues. It involves making the use of health services a positive, empowering experience that helps women to increase self-health consciousness, as a step to overcome their overall social situation.

**RECOMMENDATIONS FOR THE FUTURE**

**Overall Recommendations**

- **Increase affordability of services**
  This includes national and local government measures to increase health budgets and ensure that poor and low-income women and men do not have to pay for medication, blood, services or ambulance costs. The financing of health services and the impact of health sector reforms need to be monitored and studied at local and national levels for its impact on service costs.

- **Training curriculum**
  Curriculum of doctors and nurses require reorientation to a broader socio-cultural framework of health determinants including gender, rights, poverty and culture and religion. Interpersonal communication skills with emphasis on respect and dignity of clients need to be added.

- **Establish feedback mechanisms for women clients**
  Management and health providers need to establish ways of obtaining regular feedback from women clients on their needs and the quality of services. These mechanisms could range from suggestion boxes to client committees, surveys, focus groups etc.

- **Removal of gender bias in health services**
  Health service organisations which have practices and/or procedural requirements of consent from husbands for sterilisation or abortion, need to abolish these as they are a violation of gender equality requirements in the Women’s Convention Against All Forms of Discrimination of Women. At the national level, national health, population and women’s health policies need to be examined and if necessary, include a statement that such a gender bias will not be permitted in health services.

- **Gender-sensitive health services**
  At the service/organisation level, a clear policy and operational framework for planning, implementing and evaluating gender-sensitive health services needs to be adopted and implemented. At the national level, national health population and women’s health policies need to include the goal of gender-sensitive health services in line with the Beijing Conference recommendations.

- **Education of women clients and communities on gender issues and health rights**
  Health service information needs to include relevant gender issues and client’s rights, especially violence against women and the sexual and reproductive rights of women to decide on contraception, abortion and childbirth.

  Women, health and development NGOs working with women and communities need to educate women and communities on gender and rights issues particularly to change norms and attitudes on women’s mobility and independence which affect their health service-seeking behaviour.

- **Policy and programme advocacy**
  Women’s and health NGOs need to convince health service management and providers of the need to provide higher quality
and accessible gender-sensitive services for women through advocacy, backed by research on the gaps in health services. Frameworks, tools, and best practice models and materials need to be promoted and shared to assist in operationalising gender-sensitive services. Women themselves at community level need to be mobilised as advocates to express their needs, rights, and experiences of health services and engage with the health system to make it more accountable to its clients.

**Recommendations for Action Addressed to Specific Stakeholders**

**Women’s health NGOs**
- Work closely with government and NGO health services to provide technical assistance to evaluate and plan health services to be women-centred and gender-sensitive.
- Educate women in communities on their health rights and train them to negotiate with health providers.
- Develop, disseminate, promote and share key information and tools including indicators for evaluation.
- Act as resource people for health service technical meetings, seminars and training programmes.
- Identify, document and promote effective women-centred and gender-sensitive health service models for women.
- Actively network with each other to share tools, experiences and lessons learned.

**Women’s health researchers/women’s studies researchers need to:**
- Assist women NGOs in evaluation, monitoring and research on health service implementation.
- Collaborate with mainstream health research initiatives to provide qualitative research methodology and gender-sensitive frameworks.
- Help train more women NGOs to improve their health research capacity.
- Take on board health sector reform impact as a key health issue related to accessibility and affordability and integrate this in ongoing research.
- Actively network with each other to share tools, experiences and lessons learned.

**Health service providers (governments and NGOs)**
- Hold periodic horizontal and multi-disciplinary meetings with staff members to reorient service processes to improve quality and gender-sensitivity.
- Promote the idea that health visits be learning processes for users and providers, helping women express their needs, ask questions they have, and to explain all procedures done and needed in each case.
- Be oriented to women’s rights and gender-sensitive health services and know why and how to integrate a rights and gender approach in health services.
- Be able to input their concerns and views for change in health services to management through regular mechanisms.
- Participate in the design and distribution of health education materials addressed to women users, their partners and families.
- Have their work conditions improved – reduction of workload, adequate staffing and salary and a less hierarchical working environment especially for auxiliary health workers.

**Health service management (governments and NGOs)**
- Recognise efforts of health personnel by giving them recognition and incentives.
- Be oriented to health sector reform, women’s rights and gender-sensitive health services and develop programme policies on women’s rights and gender.
- Advocate for an increase in budget allocation for their organisations/services.
- Develop mechanisms for regular input of women clients in giving feedback on their needs and experiences (surveys, focus groups, women’s committees etc.).
- Improve work conditions of health personnel.

**Health NGOs (family planning associations etc.)**
- Document and disseminate widely to government and NGOs their valuable models of women-centred and quality reproductive care.
- Work closely with government to evaluate government health services and provide technical assistance to operationalise a clients’ rights approach.
• Innovate with women clients, ways to educate women on their health rights and gender issues, so that women will be empowered to assert their rights in other health contexts.

**World Health Organisation**
• Monitor Ministries of Health to ensure that they comply with the recommendations of the Beijing Platform for Action as well as provide technical assistance and materials.
• Assist with governments to find and allocate funds for improving quality services from a gender perspective.

**Donors**
• Provide more resources to women’s health and rights NGOs for action research on quality of care and gender-sensitive health services, which is policy and programme oriented, as women NGOs are leading the way in enlarging this approach after Cairo and Beijing.
• Ensure that project funded health research or health services have a component on ensuring a women-centred and gender-sensitive dimension, and collaboration with women NGOs.
• Fund women NGOs information initiatives to develop, promote and disseminate conceptual and operational tools in new areas.
• Fund innovative health provider curriculum and training, and related evaluation which include women’s rights and gender-sensitivity.

**NOTES**

Tools to Evaluate Quality Gender-Sensitive Health Services

Introduction

Useful tools are essential guides for policy makers, health providers, programme managers and researchers especially in new areas in which few practical resources exist. The Cairo and Beijing+5 review documents identify as a key action that tools be shared to assist to operationalise clearly the recommendations made in the conferences. The five tools provided in this chapter have been developed by ARROW and used in this research project either as a resource for planning or for the research analysis. The tools are aimed to assist in the evaluation of health services and programmes towards greater sensitivity to gender and women’s rights issues.

The tools comprise of:

- Beijing Recommendations on Gender-Sensitivity
- Definitions
- Framework to Measure Women’s Access to Quality Gender-Sensitive Health Services
- Checklist of Gender-Sensitivity of a Health Organisation or Programme
- A Framework for Women-Centred and Gender-Sensitive Policies and Programmes for Women’s Health, Post-Cairo and Beijing
**TOOL I**

**Beijing Recommendations on Gender-Sensitivity**

**How to Use This Tool**

This tool contains paragraphs from the Beijing Platform for Action, recommending gender-sensitive approaches in programme implementation, training and research. These could be useful to refer to or disseminate when advocating for change of health policies and programmes towards greater sensitivity. You may want to make transparencies or handouts of this tool for group discussion and presentation.

**Actions to be taken**

- Design and implement, in co-operation with women and community-based organizations, gender-sensitive health programmes, including decentralized health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands of their time, the special needs of rural women and women with disabilities and the diversity of women’s needs arising from age and socio-economic and cultural differences, among others (Beijing Platform for Action, para. 106c).

- Ensure that medical school curricula and other health care training include gender-sensitive, comprehensive and mandatory courses on women’s health (Beijing Platform for Action, para. 107p).

**Strategic Objective**

Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues (Beijing Platform for Action, Objective C-3).

**Actions to be taken**

- Develop gender-sensitive multi-sectoral programmes and strategies to end social subordination of women and girls and to ensure their social and economic empowerment and equality; facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases (Beijing Platform for Action, para. 108e).

- Promote gender-sensitive and women-centred health research, treatment and technology and link traditional and indigenous knowledge with modern medicine, making information available to women to enable them to make informed and responsible decisions (Beijing Platform for Action, para.109b).

- Support and fund social, economic, political and cultural research on how gender-based inequalities affect women’s health, including etiology, epidemiology, provision and utilization of services and eventual outcome of treatment (Beijing Platform for Action, para. 109F).

TOOL II

Definitions

Gender-Sensitivity of Health Services

Gender-sensitivity of health services refers to the extent to which health services are planned and implemented to ensure the analysis of issues related to the unequal power relationships of men and women. Unequal relationships or gender inequality affects women's access to services and the provision of the care and services women need in order to prevent and resolve their health problems and promote gender-equality. Overall, gender-sensitive services do not reinforce gender roles and stereotyped behaviour, but actively aim to challenge gender-inequality and promote women’s rights and autonomy in deciding on and having their health needs met.

Key issues which gender-sensitive services address are:

- Women's rights to be acknowledged and respected as an equal partner in decision-making with their men partner in relation to initiating or declining sexual relations, safe sex practices and sexual pleasure.
- Women's right to be free from all forms of violence perpetuated by men.
- Women's right to decide if they want to be supported by their partner in the resolution of their health needs and problems.
- The reproductive rights of women to decide whether and when to have children. Women's need to exercise reproductive rights are greater than the rights of men due to women physically bearing, giving birth to and breastfeeding children.

Men’s involvement in women’s sexual and reproductive health decisions and services is a critical component of gender-sensitivity but the concept needs to always be addressed within the context of the goal of gender-equality. Men’s involvement as a strategy towards gender-equality has nothing to do with the provision of reproductive health services for men as is commonly misunderstood.

Women-Centred

The research aims to be women-centred focusing on women’s needs and experiences as articulated by women themselves. As described in Tool No. 5 of ARROW’s Resource Kit, “women-centred means that the needs, values, information, experiences and issues from the point of view of women are considered and incorporated in the planning, implementation and evaluation processes of policies and programmes which affect women’s lives”.
TOOL III

Framework to Measure Women’s Access to Quality, Gender-Sensitive Health Services

Introduction

Indicators to measure women’s human rights and gender, are integrated into each component of this framework. The five components are: comprehensiveness of information; comprehensiveness of women’s health services; respect for women’s human rights; infrastructure and facilities; and technical competence of providers.

The framework was developed after the completion of the six case studies in ARROW’s research project on “Women’s Access to Gender-sensitive Health Services”. It was used as a tool for further analysis of the comparative findings by the research team. The indicators are generally derived from the measures used by researchers in individual case studies. They have been organised under five elements expanding on Judith Bruce’s six elements on quality of care and the initial framework for this project proposed at the Researcher’s Planning Meeting. The Bruce element of interpersonal relations has been expanded and re-named as respect for women’s human rights. In addition, several key indicators from the IPPF Manual to Evaluate Quality of Care From a Gender Perspective were added. These indicators are referenced in the framework.

How to Use This Tool

The framework can be used by government and NGO policy makers, programme managers and service providers as a tool to evaluate the quality of health services in general and also specifically for women. It can be applied to a broad range of health services including women’s health, reproductive health, contraceptive services and childbirth. The emphasis of the indicators, however, is on reproductive health services. The framework can be used as a tool in its present form, or adapted by including other indicators. Besides research and evaluation activities, the framework can be used in training programmes for policy makers, programme managers and service providers on quality of care, women’s rights, and gender-sensitivity.
Framework to Measure Women’s Access to Quality, Gender-Sensitive Health Services

i. Comprehensiveness of Information

• Adequacy of the content of information given to resolve or prevent the health problem.

• Extent to which the information includes the recognition of the promotion of the rights of clients to information and quality health care.

• Adequacy of information given recognising and promoting women's self health care measures.

• Adequacy of pamphlet or written information content and promotion of pamphlet.

• Extent to which women providers are available for medical examination and childbirth.

• Extent of provision of information during relevant women’s health services, on the following key gender and women's rights issues
  - violence against women
  - contraception
  - sexual relations
  - rights and negotiation in decision-making between women and men towards gender-equality.

• Scheduling of service time and waiting time takes into consideration women’s and men’s gender roles in the household (e.g. childcare and cooking).

ii. Comprehensiveness of Women’s Health Services

• Adequacy of integration and provision of related health services in areas such as STDs, RTIs, cancer screening, sexuality, HIV/AIDS and VAW, contraception, MCH, emergency obstetrics and mental health, in order to meet women's total health needs.

• Extent to which providers' ask women if they want their men partners' involvement in resolving their health needs and problems and extent that providers follow up by encouraging the men partners to take responsible action.

• Extent to which the services provided do not reinforce unequal gender roles and gender stereotyped behaviour but promote gender-equality, e.g. extent that men are allowed and encouraged to participate in the childbirth process, decisions on contraceptive methods and STD screening and treatment.
iii. Respect for Women’s Human Rights

- Adequacy of respect shown to women (e.g. absence of scolding, rudeness, mistreatment).
- Adequacy of care shown to women including emotional support.
- Confidentiality principles practiced.
- Extent to which women are allowed and encouraged to ask questions, express suggestions and give feedback and complaints to service providers.
- Extent to which women participate equally in decision-making with partner and/or service provider when a choice has to be made such as family planning contraceptive method, childbirth position, caesarean birth, and other routine and emergency medical procedures.
- Extent to which women’s health decisions or agreements are based on informed consent (i.e. up to date and accurate information on the method and procedure is given including advantages and disadvantages, risks and benefits, costs, etc.).
- Adequacy of service provider’s language, both appropriateness of level of complexity of expression, and the use of local languages and medical terms etc.
- Extent of acknowledgement and respect of women’s own knowledge, practice and experience related to the health problem including the links to culture and religion.
- Extent to which husband’s notification and/or consent is not required for specific reproductive procedures (e.g. ligation, abortion and caesarean births etc.), procedures on this exist and women can decide autonomously.

iv. Infrastructure and facilities:

- Adequacy of quantity and quality of:
  - health facilities
  - equipment
  - drugs
  - child care areas
  - security/safety features
  - privacy for consultations and treatment
  - allocation of toilets and hospital beds according to gender needs (e.g. more women outpatient toilets than men as more women users).
- Extent of gender bias of service availability or provision made for a particular sex (e.g. allocation of hospital beds by gender).
v. Technical competence of providers

- Adequacy of protocols and procedures regarding health care and treatment.
- Adequacy of technical treatment, procedures and information.
- Adequacy of medical records.
- Extent mechanisms exist for eliciting regular feedback from women on the quality of services and evaluating their satisfaction with services.
- Extent of protocols to build in women’s feedback into provider-women interaction and service provision.
- Existence and use of client suggestion or complaint boxes.
- Capacity for conducting periodic qualitative research studies on quality of health care from women’s perspectives.
- Extent evaluation procedures exist to assess the women’s overall satisfaction with the services provided.
- Extent of provider knowledge on poverty; women’s rights; gender issues in health, sexuality, and reproduction; and on community services for referral of women who have been abused.

NOTES

1 International Planned Parenthood Federation/Western Hemisphere Region. 2000. Manual to Evaluate Quality of Care From a Gender Perspective. New York: IPPF/WHR.
TOOL IV

Checklist of Gender-Sensitivity of a Health Organisation or a Programme

How to Use This Tool

This tool provides five key indicators to use to assess quickly the extent to which gender roles and gender-equality issues have or have not been addressed in an organisation. This could be measured both at the level of the organisation itself and the programme overall. Most of these indicators refer directly to an organisation providing health services. The tool can be adapted and used in reviewing an organisation’s gender-sensitivity and in training sessions on gender-sensitive programmes and organisations.

• Existence and implementation of organisational policies and procedures on gender equality, sexual harassment and gender discrimination

• Ratio of male and female health service providers in various levels, positions and categories and the extent of male-female hierarchy.

• Extent of gender bias regarding differences in health service providers’ work conditions.

• Provision of child care facilities for clients and health service providers.

• Gender roles of staff considered in working conditions (e.g. hours and schedule required to work; time off permitted; breastfeeding breaks; four months maternity leave according to ILO Guidelines).
### TOOL V

**A Framework for Women-Centred and Gender-Sensitive Policies and Programmes for Women’s Health, Post-Cairo and Beijing**

**How to Use This Tool**

This framework is a summary comparing women-centred and gender-sensitive policies and programmes for women's health as described in the ICPD Programme of Action (POA), Cairo, and the Beijing Platform for Action (PFA) to earlier approaches to women's health. You may want to use this tool in reviewing or re-designing your country's or organisation's policies and programmes, during presentations or group discussions related to implementing the ICPD POA and the Beijing PFA, and in gender-sensitisation training sessions. The tool has been adapted and used by a number of organisations both national and international including WHO, the European Union Reproductive Health Programme and ICOMP.

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<td><strong>Concept of Women's Health</strong></td>
<td>A narrow bio-medical meaning in terms of a state of absence of illness and disease. Focus on women's reproduction and role as mothers. Health not seen as a right.</td>
<td>The emotional, social and physical well-being of women determined by the social, political and economic context of women's lives as well as by the biological context. Health stated as a right.</td>
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<td><strong>Goals</strong></td>
<td>Improve primarily the physical health of women of child-bearing age during pregnancy and childbirth.</td>
<td>Attain a high standard of physical, social and emotional well-being for women of all ages.</td>
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<td>Increase women’s control over their bodies (i.e., their reproductive rights) and ultimately their lives.</td>
<td>Change socio-economic and cultural conditions which are barriers to women's right to good health, their reproductive rights and their equality with men (e.g. women’s legal status, education, poverty level, decision-making power in the household).</td>
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<tr>
<td><strong>Beliefs and Values</strong></td>
<td>Women's health is biological. Ill health is due to weakness and lack of care/deterioration of the body.</td>
<td>Women's health is determined by social, political, cultural and economic factors as well as biological ones. Gender is a cultural factor. Inequality between women and men (gender inequality) is a major obstacle to the attainment of good health.</td>
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<td><strong>Determinants of women’s health</strong></td>
<td>The role and identity of women as mothers (social reproduction) is the most important role women play in society.</td>
<td>Women of all ages and marital and motherhood status play many important roles in society contributing to economic, social and family development. Motherhood is only one of these roles (which not all women experience or want to experience) and this spans only about 15 to 20 years of a woman's life.</td>
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<tr>
<td><strong>Gender roles, identity responsibilities</strong></td>
<td>Women have the most responsibility for reproductive health matters as they bear children.</td>
<td>Men have equal personal and social responsibility for the effects of their own sexual behaviour on their partners' and children's health and well-being and need to control their fertility by using contraception and by practising safe sex.</td>
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<td>Women have the main responsibility for child care and domestic work due to their biological (sex) role as mothers.</td>
<td>Both women and men have a shared responsibility for the care and nurturing of children and maintenance of the household as part of gender equality in the family.</td>
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<td>National goals such as demographic priorities (that is, to increase/decrease the population) are more important than the human rights of individuals.</td>
<td>Women have the individual right and the social responsibility to decide whether, how and when to have children and how many to have; no woman can be compelled to bear a child or be prevented from doing so against her will.</td>
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<td>Individual rights (continued)</td>
<td>The medical profession knows best what women's health needs are and what services to provide.</td>
<td>Women's own expression of their experiences and understanding of their bodies and lives is critical to determining their health needs (women-centred). Women have the right to be listened to and to request and demand access to appropriate, acceptable and affordable comprehensive health services of high standards.</td>
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</tbody>
</table>
| Programme Objectives | • To reduce maternal mortality  
• To reduce infant mortality  
• To increase use of contraception | Improve services to meet the total health needs of women, promote gender equality and eliminate barriers to the attainment of a high standard of health for women. |
| Programme Approaches | • Primary health care approach; preventive and medical treatment  
• Family planning  
• Culture considered, i.e. food taboos during pregnancy and after childbirth | • Comprehensive women's health services  
• Reproductive health services within the context of women's rights and women's reproductive rights  
• Empowerment of women; efforts to overcome barriers to exercising right to good health such as culture, religion, economics, gender, etc. by initiating or supporting other programmes’ efforts. |
| Service Range | • narrow  
• ante-natal and post-natal services for mothers  
• contraception for married women | • comprehensive  
• maternal health  
• reproductive cancers  
• STDs  
• HIV/AIDS  
• sexuality  
• nutrition  
• contraception  
• RTIs  
• occupational health |
<table>
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<tr>
<th>Area for Change</th>
<th>Primary Health, Maternal Health and Family Planning 1970’s and 1980’s</th>
<th>Women-Centred and Gender-Sensitive, Post-Cairo and Beijing 1990’s and beyond 2000</th>
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| **Service Range** (continued) | | • mental health  
• violence against women  
• services provided in the context of women’s rights and gender-power relationships (eg. husband, father, state) |
| **Age of Women and Marital Status** | Married women of reproductive age (15-49 years). | All ages from primary school to older women, unmarried and married. |
| **Accountability** | First priority is to the organization, then the funders. | The women clients are seen to own the programme, and mechanisms to bring this about are built into the programme planning, implementation, evaluation and management. |
| **Women’s Health Indicators** | • Quantitative measures of death (mortality) of mothers and babies, i.e. maternal mortality rate, infant mortality rate, etc.  
• Length of women’s life, i.e. life expectancy.  
• Number of contraceptive users and the fertility rate. | • Quantitative measures of the prevalence of all major health problems experienced by women (see service range) and the extent to which services are available and actually accessible to women.  
• Qualitative measures with much emphasis on women’s satisfaction with services, improvement in well-being and control over their lives (i.e. empowerment).  
• Measures of well-being rather than death (mortality). |

Source:  
*Asian-Pacific Resource & Research Centre for Women (ARROW), 1996.*  
Researchers’ Acknowledgements

Pakistan

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Bangladesh

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Sri Lanka

Our thanks to Professor Swarna Jayaweera, coordinator CENWOR, who nominated the researchers to conduct the study. Our appreciation also to Dr Tara Del Mel, advisor to the president of the Social Infrastructure, members of the Task Force on “Safety and Welfare of FTZ Women Workers” for approving the research proposal and the officials at the selected FTZ, without whose interest, cooperation and assistance it would have been impossible to accomplish this task. We are most grateful to the provincial Director of health services and the Director district health services, Ministry of Health and the team of midwives who assisted us in the survey. A special word of thanks to the CENWOR staff; Nandini Wanashinhe (accountant), Nirmali Amarasiri (librarian), Dharshini de Silva (assistant), Suharshini de Silva (Research & Publications officer) and Siva Sivasubramiam, who was responsible for the analysis together with Vathany Narendran and the data operators.
THIS BOOK offers readers some insight on women’s needs and experiences of health services as articulated by the women themselves. This women-centred qualitative research is also innovative for its action component focusing on bringing about changes in health services as an immediate outcome of the research process.

Participatory-style research methodology and intervention were designed and implemented in cooperation with service providers, women clients themselves and women’s organisations in the following six country studies: Bangladesh, the Philippines, Malaysia, Sri Lanka, Pakistan and China. The country studies assessed the progress and obstacles experienced by governmental and non-governmental health organisations towards planning and implementing programmes for women which are affordable, accessible, gender-sensitive, of high quality and women-centred. A tools section provides frameworks and definitions which can be used to evaluate the quality and gender-sensitivity of health programmes.

This book would be useful to governments, international institutions and non-governmental organisations who are committed to review their health programmes for women as recommended by the Beijing Platform for Action.