Health and Poverty Gender Analysis

Briefing prepared for the Swedish International Development Co-operation Agency (Sida)

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with Sarah Cook

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### ACRONYMS

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<th>Acronym</th>
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<tr>
<td>DALYS</td>
<td>Disability Adjusted Life Years</td>
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<tr>
<td>HHPH</td>
<td>Household Production of Health</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HSR</td>
<td>Health Sector Reform</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Healthcare</td>
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<tr>
<td>ORT</td>
<td>Oral rehydration therapy</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>SAPs</td>
<td>Structural Adjustment Programmes</td>
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<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
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<td>UN</td>
<td>United Nations</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. EXECUTIVE SUMMARY

Policies to improve the health status of the poor have been an important focus of development policy, justified by the recognition that good health is a basic right as well as a critical determinant of economic productivity. Health sector policy has addressed poverty issues to the extent that policy makers focus on the delivery of basic free or low-cost services to the poor. Health and well being, however, are also dependent on health seeking behaviour and on a range of environmental, social and cultural factors, suggesting a need for greater understanding among policy makers of individual and household demand for health, and of its wider determinants.

To date, mainstream health policy has emphasised women’s special health needs, both as a basic right, and as a cost effective means to improve child welfare, as exemplified in the provision of MCH services, but this may overemphasise the synergy between children’s and women’s health. Further, it tends to overlook non-reproductive health needs (of both poor women and men) and the broader range of gender-related factors determining health status and care. The Household Production of Health approach has the potential to integrate gender analysis more systematically in studies of health, well-being and poverty.

Progress in improving health indicators has been uneven, particularly in poor countries. Inequity in access to services for poor people and low quality care have been identified as problems in health service provision, which, it is argued, is biased towards higher income groups. Health sector reform has placed new emphasis on selected basic services and promoted cost-recovery, decentralisation and community participation, stimulating debate about the impact on the poor. Evidence suggests that in some countries, user fees have led to falls in utilisation of services by some poor groups.

The health impact of the linkages between gender concerns and poverty are most clearly seen in terms of overwork, hazardous work, and poor nutrition. Poverty and gender also have significant linkages in relation to mental illness, vulnerability to violence, and stigmatisation due to health problems. Nutrition is a key area where the combined effects of gender inequality and poverty produce ill-health for women and girls, and inter-generational transmission of poverty may occur through the undernourishment/overwork of pregnant or lactating women. Furthermore, certain conditions of ill-health may lead to women’s social exclusion and subsequent poverty, pointing to the importance of recognising a cycle of ill health and poverty. However, it is important to recognise that women’s health problems and access to health care are affected not only by poverty, but also by gender inequality.

Studies of health care seeking behaviour suggest that the constraints of poverty and gender mean that it is poor women (and girls) who are least likely to have access to appropriate care and to seek adequate treatment. The range of factors which limit access for poor women include time constraints, intra-household resource allocation and decision-making relating to health care, and legal and socio-cultural constraints. Issues of health policy, financing and service delivery also have important gender aspects, particularly in relation to budgetary allocation, the impact of user fees on poor women, and the quality of care, all issues which merit further research.

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1 This briefing was drafted by Zoë Oxaal, BRIDGE Researcher (sections 3 - 6) and Sarah Cook IDS Fellow (section 2), under the guidance of Sally Baden BRIDGE Manager.
A gender analysis of health and poverty suggests the need for policies which pay attention to the broad range of women’s health needs, not just reproductive health. Efforts must also be made to ensure that health sector reform strategies do not put extra-heavy burdens on poor women through increased demands on their time or incomes. Improvements in quality of care, which take account of women’s perceptions and experiences, is important in order to increase demand for services. Furthermore, this analysis suggests the need for multidisciplinary inputs into the design and implementation of health policies and projects, for the systematic collection and use of gender-disaggregated data in health policy and planning and for non-health sector strategies to address socio-economic and legal constraints to improved health.
2. MAINSTREAM DEBATES ON HEALTH AND POVERTY

2.1 Health and poverty

Policies to improve the health status of the poor, particularly through the provision of basic health services, have been an important focus of development policy over the past 25 years, a focus which is justified

- by the recognition that good health is an end in itself and a basic right; and

- that it is a critical determinant of factors which contribute to economic growth.2

The view of health or well-being as a basic right has led many governments and donors to ascribe to the goal of universal provision of some basic level of health care. In practice, however, economic retrenchment and adjustment has resulted in a stronger emphasis on the second justification - on efficiency grounds, that improving the health of the poor will raise their productivity and contribute to economic growth.

In reviewing health sector achievements, particularly in poor countries, over the past 40 years, the World Bank (1993) pointed to the uneven pace of progress in improving basic indicators such as life expectancy and child mortality, the variation in the burden of disease3 across countries and regions, and the new health challenges posed, for example, by the spread of HIV/AIDS (ibid.: 1). Among the problems identified in the provision of services was inequity, with poor people lacking access to basic health services and receiving low-quality care (ibid.: 4). Government spending for health was seen to go disproportionately to the affluent in the form of free- or below cost care.

Health sector policy has generally been concerned primarily with technical solutions to the provision of health services or care. Poverty issues are addressed to the extent that policy makers focus on the delivery of basic free or low-cost services to the poor. Emphasis has been placed on public health interventions such as immunisation campaigns, which have directly benefited the poor as well as having externalities for the wider population. Another increasingly important area of policy concern, most directly affecting women’s health, is the provision of MCH and reproductive-related health services, often closely linked to a country’s population policy (whether pro- or anti-natalist).

The ultimate goal of health policy, however, is the production or maintenance of good health or well-being, for which health services are only one of many critical inputs. Policy makers thus need to understand the individual or household level demand for health care, and the ways in which health inputs are translated into the desired good or commodity - health - in order to determine the appropriate type and quality of services, and to design appropriate delivery mechanisms. The demand for health services depends on a range of factors at the individual / household level, including the willingness or ability to pay for services, perceptions of health status, and information about and access to the services offered. The

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2The growing recognition of the important role of health in economic development is illustrated by the use of health measures as indicators of overall development (Berman, 1990).

3Measured by Disability Adjusted Life Years (DALYs) (e.g. Murray, 1993).
capacity to translate health inputs into the commodity of health or well-being depends additionally on a range of environmental, social and cultural factors such as nutrition and sanitation practices.

The focus on health as a means towards broader developmental ends, and the exploration of the wider determinants of health, have led to a greater focus on non-health interventions as important mechanisms for improving the health status of the poor and for alleviating poverty. Based on evidence that strong links exist between female education and indicators of health status, the World Bank has placed a strong emphasis on the education of girls and women as a cost-effective way to improving health (World Bank, 1993: 8). More generally, increasing household incomes is argued to be the most efficacious method for improving health status as ‘the poor are most likely to spend additional income in ways that enhance their health’ (World Bank, 1993:7).

2.2 Health care provision

The debates on, and policy approaches towards, health service provision have been shaped by changing global economic trends. The comprehensive primary health care focus of the 1970s, gave way to more selective interventions and a move towards cost-recovery, in the face of economic crisis, recession and adjustment of the 1980s.

Health care for the poor - Primary Health Care

The Primary Health Care (PHC) approach was developed to decentralise health provision, devolve responsibility away from professionals towards the community, and to emphasise preventive rather than curative care (Kabeer and Raikes, 1992). Following the 1978 Alma Ata Declaration, developing countries subscribed to ambitious health goals through the provision of widespread PHC services including immunisations, pre-natal and pre-school care and basic curative services. The plan was optimistic of the potential for comprehensive provision of basic services, but by the mid-1980s several weaknesses of the PHC approach had become apparent. These included an unclear definition or notion of community (McPake et al. 1993), lack of sustainability and problems with local institutions and management. Insufficient attention had been paid to micro-level or individual behaviour patterns which were essential for the success of such an agenda (Akin et al., 1986).

The response to the limitations of PHC included an adaptation of the comprehensive PHC approach towards a focus on more selective health interventions, and the achievement of universal access through decentralisation of decision-making, community financing, participation and management (McPake et al., 1993:1383) articulated in the Bamako Initiative. Launched in 1987 at a meeting of several African government leaders, and supported by UNICEF and WHO, its principal aim was to ‘revitalise the public sector health care delivery system [by] strengthening district management [and] capturing some of the resources the people themselves are spending on health’ (UNICEF 1992 in World Bank, 1993:159).
Health sector reform

The 1980s also saw governments cutting social sector budgets in response to economic crisis and as part of adjustment packages, with serious implications for health service provision and more generally for the health status of certain sectors of the population, particularly the poor and ‘vulnerable’ groups (Cornia et al., 1987).

The widespread response to adjustment and public sector retrenchment has been health sector reform along the principles laid out in the World Development Report, 1993. Health sector reform refers to a package of policies for the financing and provision of services, emphasising cost-effectiveness through the provision of relatively low-cost, high-impact interventions, such as public health programmes, increasing efficiency through competition between providers and greater private sector provision, and the introduction of cost-recovery mechanisms such as user fees, pre-payment and insurance (World Bank, 1993; Cassels, 1995). Against the background of economic crisis, the objective of universal coverage was retained in principle, to be achieved by ‘making more efficient use of available resources through institutional reforms and widening the range of financing options and institutional players who provide health care’ (Standing, 1997).

2.3 The demand for health care

The pursuit of health sector reform has stimulated debate about the impact on the poor, particularly of the introduction of cost-recovery mechanisms such as user fees (Standing, 1997). The success of any reforms in provision and financing, and their ultimate health outcomes, are dependent on how price changes and alternative pricing systems affect the utilisation of services among different population groups. This information is obtained through studies of the demand for health care.

The results of such studies have been mixed (Bitran, 1988:6). Early studies found that prices charged by providers have an unimportant effect on the choice of provider and the amount of care consumed (Akin, 1985). Such evidence that prices are not important determinants of demand provides a justification for the widespread introduction of user fees. One explanation given for this finding is the idea that health care is valued as a commodity if it has a price. When it is provided free of charge, it may be regarded as of inferior quality and not valued. Thus poor households may demand more services if there is some price attached. Secondly, price may not be the main constraint on utilisation - even with free or low cost services, other factors prevent utilisation such as indirect costs of transport, or the opportunity costs of time. Thirdly, perceptions about ill-health, and thus the perceived need for health care, may vary by income group with the poor less likely to seek care. These arguments raise the possibility that untargeted subsidies which lower the cost of health care disproportionately benefit higher income groups who use services more than the poor (Akin, 1986).

By contrast, Gertler et al. (1986) suggest that fees may indeed have an important effect on demand, and that the poor are more adversely affected by prices than people with higher incomes and wealth. More recent evidence also suggests that the introduction of user fees for health services has led to falls in utilisation rates, temporary for some groups, but with long-term implications for the rural poor (e.g. Waddington and Enyimayew, 1989). In addition,
exemption systems designed to protect the poor have not functioned effectively (Hamner et al. 1996: 6.19).

2.4 The household production of health

A more recent body of economic literature explores how health is produced within the household. Berman et al. (1990) defines the household production of health (HHPH) as ‘a dynamic behavioural process through which households combine their (internal) knowledge, resources and behavioural norms and patterns with available (external) technologies, services, information and skills to restore, maintain and promote the health of their members’. The focus thus shifts from the public sector to the domestic domain or household, (ibid.) and from the provision of services and technology to the behavioural relationships which determine the effectiveness of the technologies (Da Vanzo and Gertler, 1990).

Such an approach challenges the common use by researchers and policy makers of the household as the appropriate unit of analysis, and focuses attention on the allocation of resources within the household along dimensions such as age and sex (Piwoz and Viteri, 1985). It also highlights the role of women, particularly their time inputs, in the process of health production and maintenance (Leslie, 1992). Finally, by examining a wider set of factors which determine health outcomes, it provides greater potential for moving towards an understanding of the complex interactions between health/well-being and poverty.
3. HOW MAINSTREAM HEALTH AND POVERTY DEBATES HAVE ADDRESSED GENDER EQUALITY

3.1 Approaches to women and gender in health care

Two different approaches to gender in relation to health care can be distinguished:

- **women’s health needs**: this approach is concerned with the implications for women of differences in the epidemiological profile between the sexes. It highlights the specific health needs of women and girls as a consequence particularly (although not exclusively) of the biology of reproduction.

- **gender equality**: this approach to health is concerned with the role of gender relations in the production of vulnerability to ill health or disadvantage within health care systems, and particularly the conditions which promote inequality between the sexes in relation to access and utilisation of services (Standing, 1997).

Of these two approaches it is the women’s health approach which has been most widely adopted in mainstream debate and in international agencies. Standing (*ibid.*) identifies two broad stances which derive from this approach. The first advocates the need for specific women-focused health interventions as a basic right. The second stresses the cost-effectiveness of interventions targeted at women and girls, particularly as a means to improve infant health. This overlaps with poverty reduction agenda where women have increasingly become seen as the most effective conduit to improving household and child welfare. Examples of this approach are the World Bank’s 1994 *New Agenda for Women’s Health and Nutrition*, and WHO’s Position Paper *Women’s Health* 1995.

The prominence of the rationale of improving infant welfare through improving women’s health has led to a focus on women as mothers, and the provision of MCH services. The recent high profile given to the issue of maternal mortality on the international health agenda, exemplifies this tendency to have one eye on women’s health and the other on the benefits for children. Emphasising the synergies between maternal and infant welfare, and the subsequent cost-effectiveness of maternal health interventions may be useful in persuading governments to invest in women’s health. However, the assumption that what is good for women’s health is necessarily beneficial for children’s health and vice versa may be too simplistic and lead to mistaken assumptions.4

A focus on women’s reproductive health runs the danger of neglecting women’s (and men’s) non-reproductive health problems and care needs. To some extent mainstream debate has taken this on board, for example by placing violence against women onto the health agenda, and the adoption of a life cycle approach encompassing infancy, childhood and adolescence, and problems of ageing in the post-reproductive years (World Bank, 1994). How far these concerns are reflected in the allocation of funds for research and services is another matter. The concentration on reproductive issues in the mainstream discourse on women’s health needs in developing countries has important implications for health policy and planning,

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4 e.g. it has been inferred from evidence that close birth spacing has a negative impact on infant health that close spacing is also harmful to women's health, but research does not exist to prove this (Oxaal with Baden, 1996).
especially at a time when due to crisis and adjustment, comprehensive primary health care is being challenged and the emphasis is shifting to selective programmes (Lewis and Kieffer, 1994). Lewis and Kieffer argue for the adoption of a definition of ‘safe womanhood’ which would encompass the already well accepted notion of ‘safe motherhood’ and include much more besides (ibid.). The range of essential services to women’s health proposed by the World Bank, shows an almost exclusive focus on reproductive health. The World Bank propose that governments of even the poorest countries should fund these and that private sources should finance expanded services which meet a broader range of needs. For poor women (and men) this may translate to a lack of accessible services for non-reproductive health needs.

3.2 Poverty and the women’s health needs approach

A focus on poverty in women’s health provides an opportunity to broaden the idea of what constitute women’s health needs away from the current focus on reproductive health. Thinking about women and poverty can draw attention to health problems arising from the wide scope of women’s activities and how gendered patterns of disease and health risk are affected by socioeconomic position. However it is important to recognise that women’s health problems and access to health care are affected not only by poverty, but also by gender inequality. Even women in less poor households may not place priority on meeting their own health needs. There is recognition in the mainstream debate that poverty can not explain all the health problems of women. According to WHO, the correlation between poverty and poor health for women is not a direct one.

Economic growth does not necessarily guarantee better health or higher status for all women because the benefits are not equally distributed. . . A deteriorating economic situation can create severe health risks for women even when they do not live in extreme poverty (WHO 1995).

Attention must also paid to ensure that health sector strategies do not put extra-heavy burdens on poor women. For example, Kabeer and Raikes (1992) point out that intensive breast feeding strategies place heavy demands especially on poor women. Furthermore, reform of the health sector impacts on women’s poverty by reducing women’s employment in the health sector. The viability of PHC often depends upon female health workers who are given the task of supporting and working with the community and are frequently under-resourced. The reliance on women’s unpaid care work in the household puts further strain on poor women.

Mainstream debate has increasingly emphasised the benefits of women’s participation in health programmes (World Bank, 1994). Well-executed participatory initiatives can be valuable for identifying women’s perspectives on their own health needs and may highlight how poverty and gender interact. Participatory approaches to training health workers in developing countries can enable them to adapt more empathetic ways of communicating with the poor. This can lead to health workers and patients exploring sensitive health-related issues (e.g. domestic violence) which would otherwise never get mentioned (Welbourn, 1992).
The women’s health needs approach has been valuable in bringing attention and resources to sex-specific health concerns. Moving towards a broader understanding of women’s health should not obscure the importance and value of reproductive health programmes. However looking at women’s health needs should be encompassed as part of a gendered perspective on health and not as separate to it. A gender perspective on health, highlights socio-economic, political and cultural factors determining health status and care and allows for better understanding of the links between women’s health and poverty.
4. WHY A GENDER PERSPECTIVE IS IMPORTANT IN LINKING HEALTH AND POVERTY CONCERNS

4.1 Gender, definitions of well-being and poverty

Both feminist analyses of women’s health, and gender analyses of poverty point to the need for a broader understanding of what constitutes women’s well-being. A gender perspective broadens the meanings of poverty and health. Naila Kabeer has highlighted how income/consumption based definitions of poverty are male-biased. For women, who are often excluded from the cash economy, a broader measure of well-being, including health, may be more accurate definition of poverty (Kabeer, 1996). Measurements of poverty based on household income also obscure processes of intra-household resource allocation which have significance for women’s health and capacity to seek health care. Feminist views on women’s health emphasise the need for a holistic approach which includes self esteem, personal autonomy, freedom from violence, and sexual choice.

Inequality and powerlessness are also increasingly seen as being important root causes of ill health. This has gender implications as women are commonly less powerful in their societies/communities than men. Low self-esteem, related to a low status, can lead women to neglect of their own health needs. Poor education and lack of self-esteem may lead to women being unaware that they are suffering from a condition which can be successfully treated, particularly with reproductive health problems. For example, Key (1987) argues that in India, the perceived need for medical help is determined partly by socio-cultural factors governing how pain and discomfort are expressed, how illness symptoms are recognised and which symptoms are perceived to warrant medical care (cited in Tipping, 1995).

4.2 Gendered determinants of ill-health

The health impact of the linkages between gender concerns and poverty are most clearly seen in terms of overwork, hazardous work, and poor nutrition. Poverty and gender also have significant linkages in relation to mental illness, vulnerability to violence, and stigmatisation due to health conditions.

Gender-specific labour tasks lead to specific environmental risks and thus to different causes of morbidity and mortality for women. For example, women’s risk of exposure to certain tropical disease differs from men’s as a result of gender roles related to water (scistosomiasis), cultivation (malaria, filariasis), and domestic roles (dengue, Chagas’ disease, and leishmaniasis)(WHO, 1995). Where poverty leads to increasingly heavy work burdens for women it also implies increased risk of ill-health. Table 1 outlines gender-specific, work-related health risks for women.
Table 1: Work related health risks for women

<table>
<thead>
<tr>
<th>health problem</th>
<th>gender specific/related cause</th>
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<tr>
<td>burns</td>
<td>female responsibility for meal preparation on open stoves or fires</td>
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<tr>
<td>sore and painful, legs, hips, shoulders/fatigue</td>
<td>carrying heavy loads, e.g. water and fuelwood</td>
</tr>
<tr>
<td>prolapsed uterus, miscarriage, stillbirth</td>
<td>carrying heavy loads, e.g. water and fuelwood</td>
</tr>
<tr>
<td>smoke pollution: cough dyspnoea, respiratory</td>
<td>cooking in poorly ventilated structures using biomass fuel sources</td>
</tr>
<tr>
<td>abnormalities, detrimental effects on foetal growth</td>
<td>work in small-farm subsistence agriculture: weeding, transplanting, threshing, post-</td>
</tr>
<tr>
<td></td>
<td>harvest processing</td>
</tr>
<tr>
<td>chronic back pain and leg problems</td>
<td>work in small-farm subsistence agriculture: weeding, transplanting, threshing, post-</td>
</tr>
<tr>
<td></td>
<td>harvest processing</td>
</tr>
<tr>
<td>exposure to toxic pesticides (with effects on unborn</td>
<td>cash crop production: prolonged exposure through hand labour, e.g. weeding, picking,</td>
</tr>
<tr>
<td>and breastfed infants)</td>
<td>sorting, in sprayed fields without protective clothing</td>
</tr>
<tr>
<td>various hazards to health and safety and</td>
<td>assembly line production: long shifts, fast paced and intensive monotonous, repetitive</td>
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<tr>
<td>exposure to carcinogens, acids, solvents, gases</td>
<td>work</td>
</tr>
<tr>
<td>byssinosis (‘brown lung’)</td>
<td>working in clothing industry</td>
</tr>
<tr>
<td>eye problems, eye-sight deterioration</td>
<td>electronic assembly line work</td>
</tr>
</tbody>
</table>

Source: Paolisso and Leslie, 1995

Poverty drives women to work in hazardous environments. A very direct link can be seen between women’s work and women’s health in the case of sex workers and the prevalence of STDs including HIV/AIDS among this group. This is exacerbated by poverty where women may be driven into sex work, or into sexual relationships for economic reasons, and therefore may not feel able to insist on condom use (Marcus, 1993). Reports from countries, particularly those in Sub-Saharan Africa undergoing structural adjustment programmes (e.g. Zimbabwe and Ghana) identify how young women concede to pressure from older men and trading sexual favours for school fees, transportation and food and clothing (Sen et al., 1994). Furthermore, unless condoms are free, they may be unaffordable to the poor. The living conditions of poverty, such as poor housing, water and sanitation facilities may mean poor conditions for sexual hygiene, and a lack of suitable places to keep and dispose of condoms.

Nutrition is a key area where the combined effects of gender inequality and poverty produce ill-health for women and girls. Kabeer (1992) argues that inter-generational transmission of poverty occurs through the undernourishment/overwork particularly of pregnant or lactating women. Nutritional and biological deficiencies are transmitted through pregnancy to young children who may then not ‘catch up’ (Baden with Milward, 1995). Studies in South Asia show that girls receive less food than boys, with poor nutrition contributing to a number of health problems and conditions. However, studies of gender differentials in food allocation indicate mixed findings and a more context-specific reality than the theory of women and girls consistently receiving less food in households (Jackson, 1996).
Much controversy has surrounded the relationship between women’s work and child welfare, in part based on fears that where women leave children to go out to work there may be negative health consequences. Recent studies, however, have shown that if both income and time effects are considered, in general, the impact of women working may be positive, because of the greater benefits to children of female income. However, this may not hold for very poor women, working long hours for low pay, or where children are themselves forced to work to supplement household income (Leslie, 1988; Baden with Milward, 1995).

Poverty contributes to mental illness as stress precipitates emotional illness and frequent bereavement, floods, fires, famines, wars, and enforced migration put the poor under great emotional pressure. A study of a Bangladesh village found that sixty-nine out of every 1000 people were found to have significant psychiatric illness and that women outnumbered men, two to one. Many were suffering from anxiety neurosis and depressive illness. Women are also less likely to be among those receiving treatment for mental illness in the developing world. One difficulty is the gap of emotional understanding between rich and predominantly male doctors and poor females (Boylan, 1991).

Gender-based violence is known to occur amongst all socio-economic groups and in all cultures. Therefore it cannot be said to be caused by poverty. However in situations of poverty and economic insecurity women may be less likely to have the resources to leave violent relationships. Links between poverty, gender and violence are also seen in situations of armed conflict or mass population movements, when women are forced to leave their homes as refugees or displaced persons are often separated from the protection of male relatives. The only means of assuring food and safety may be to accede to the demands for sexual favours made by soldiers, border guards or camp administrators (WHO 1995).

Socio-cultural practices related to gender also effect girls/women’s health. Female genital mutilation (FGM) has considerable negative impact on health. Poor women/girls may find it particularly difficult to resist FGM for fear of social exclusion. Parents may be concerned to ensure marriage prospects for daughters.

Just as resisting health damaging practices may lead to social exclusion, so too certain conditions of ill-health may lead to women’s exclusion and subsequent poverty. For example, the condition of vesico vaginal fistulae can lead to women being abandoned by their husbands and left destitute. Leishmaniasis, schistosomiasis, lymphatic filariasis and onchocerciasis cause profound incapacity and disfigurement and may influence women’s marriage prospects (WHO, 1995). This points to the importance of recognising the cycle of ill-health and poverty.
4.3 Understanding health care seeking behaviour

Gender analysis emphasises the importance of looking at not only supply-side issues in health service provision, but also demand side issues and the interrelation of the two. A gender perspective is necessary in order to understand health care seeking behaviour and decision making at the household level in the demand for health care services.

Studies of health care seeking behaviour suggest that the constraints of poverty and gender meant that it is poor women (and girls) who are least likely to have access to appropriate care and to seek adequate treatment. The range of factors which limit access for poor women include: the overall socio-economic status of households; time constraints; the composition of households (female headed, extended family etc.); intra-household resource allocation and decision-making relating to seeking health care; lack of education and employment; and legal or social constraints on access to care.

Research on health care seeking behaviour clearly shows that the socioeconomic status of households affects levels of utilisation of health care services. For example, in Ethiopia, Kloos found that the poor used higher level services less often than the non-poor and were unaware of their entitlement to ‘free treatment letters’ (Kloos, 1990 cited in Tipping 1995). Composition of households is also significant, for example, a study in Sri Lanka found greater demand for services among widows than among women with partners (Keith et al, 1990 cited ibid.). This may reflect their relative autonomy in decision-making, greater health needs or social isolation.

As women are often the principal providers of household health care, the demands on their time greatly influence household health care seeking behaviour. Poor women’s heavy work burdens and the significant opportunity costs of time in seeking care may prevent access to services. Transport costs and time to travel to health facilities, as well as long waiting times at poorly staffed health facilities, all deter people from seeking care. Health care service providers should take account of the constraints on women’s time and provide out of hours services and home visits.

As well as differences in utilisation across households, studies show that within households use of health services is differentiated by gender. A number of studies have reported that men spend more money on higher level services than women (e.g. Duggal and Amin, 1989, Heinonen, 1994 cited in Tipping, 1995), and that parents are more likely to seek medical services for sick boys than for girls (Hunte and Sultana, 1987; Paul, 1991; Stock, 1993 cited ibid.).

Levels of education (of both men and women) and maternal occupation have also been found to be significant for the utilisation of health care services. A study in the Philippines showed an increased take up of family planning with any kind of maternal employment (Becker et al, 1993 cited in Tipping, 1995). Although there is a need for more detailed information on intra-household income and expenditure patterns by gender, the available evidence suggests that women devote a higher proportion of their income to children’s nutrition and other family basic needs than do men. One implication of this is that increased female incomes may not automatically correlate with better access to health care for women themselves.
Legal factors and social norms associated with gender can also prevent women from seeking health care. For example the illegality of abortion has serious consequences for women’s health due to the risk associated with illicit abortions. Richer women can afford to seek abortions abroad where they are available safely and legally, whilst poor women are subject to the dangers of illegal abortions (Oxaal with Baden, 1996). Social restrictions on women’s mobility may prevent women from seeking health care outside the home.

4.4 Health budget allocation and health services delivery

Some health care requirements are sex-specific, relating to the differences in male and female physiology, a fact most obvious in the sphere of health needs associated to women as mothers. Health budget allocation therefore has gender implications, in terms of the balance of resources which go to areas of specific concern to female health e.g. emergency obstetric care. Changes to reorient the health sector along lines of greater equity of access may have mixed effects in terms of gender equity. For example the move to primary health care may improve access to some services for women (e.g. ante-natal care) but may not meet other of women’s specific health needs such as emergency obstetric care to prevent maternal mortality.

The increased emphasis on a selected range of PHC interventions on basic health services provision, with child health as a major focus, has not given sufficient consideration to the implications for women’s time use of practices such as growth monitoring and ORT (Leslie et al, 1986). This may be especially significant for poor women with severe time constraints. Women’s and children’s health may be targeted together in MCH budgets, but this may disguise the fact that a greater proportion of expenditure is allocated to the child-based rather than maternal interventions, or that family planning is prioritised over integrated reproductive health services.

Changes in financing mechanisms for health care, such as the introduction of user fees or insurance affect men and women differently. Some studies have shown the relationship between price and health care use to be inelastic, but a failure to disaggregate users may mask the effect of fees on the demand of vulnerable groups. Also studies which only include health care users as the sample are likely to be biased against lower income groups (who are less likely to be users). Some facility-based studies have recorded a drop in utilisation rates following the introduction of user fees, but more information is needed on which groups may account for this drop (see page 6). The effect of fees on demand may also vary according to the type of service, e.g. demand for non-curative services like antenatal care or immunisation may be more elastic, suggesting potentially negative impacts on maternal and child health. A few sources report falls in utilisation of obstetric services following the introduction of changes (Stewart 1991; Oxaal with Baden, 1996) and the ‘lumpiness’ of fees associated with childbirth may pose particular problems for cost recovery from poor households.

Little data is available on the gender dimension of the burden of cost of new financing mechanisms. It is possible that poor women may shoulder greater burden of cost through payment of fees for other members of their household, whilst receiving less care for themselves. There is a need for more empirical investigation on this issue and for greater consideration to the implications of new financing mechanisms from a gender perspective (Standing, 1997).
Pluralistic healthcare systems

Studies suggest that poor women are likely to utilise a range of health care options other than modern medical practitioners. There are pluralistic medical settings in many developing countries where a range of choices are available including government, mission and community services, modern and traditional private practitioners as well as pharmacists and commercial drug outlets (Tipping, 1995). Household based care, using home remedies of ‘over-the-counter’ drugs is often the first resort in illness. This may be particularly the case in poor households (Coop et al, 1992 and Berman et al, 1987, cited in Tipping 1995). A study by Becker et al (1993) in Metro Cebu, the Philippines, found that poorer women preferred private providers over public facilities where lower fees were charged and free drug samples were given (cited in Tipping 1995). In Benin, traditional practitioners were popular due to their lower cost and more flexible payment arrangements. Studies in Mali and Indonesia report greater use of traditional medicine by lower income households (Coppo et al, 1992, Berman et al, 1987 cited in Tipping).

Studies on the household production of health suggest the importance of looking at a variety of forms of health care including ‘traditional’ healthcare, self-care, and care at home etc. Gender analysis may show different patterns in terms of which kinds of healthcare are used by which groups. Women, and perhaps especially poor women, may be more inclined to use traditional health practitioners for certain health needs, e.g. traditional birth attendants (TBAs). This may be due to cost factors but also related to lack of cultural sensitivity and respect in mainstream health service provision (see below). Efforts to support and regulate the services of non-formal health providers, such as traditional healers may be important to improve health care for poor women. However, training of TBAs has been found to be non cost effective due to the small and infrequent amount of deliveries each TBA makes (V. Fillipi, personal communication). Another danger is that the integration of private with public health programmes will further limit services available to poor and to women by making alternative services less accessible (Feldman 1983 cited in Tipping, 1995).

Quality of care

Quality of care in health service delivery, and perceptions of quality of care, are key factors in the choice and use of health services, especially in poor households where resources are tightly limited. Until recently approaches to assessing quality have concentrated on the technical quality of service delivery. There is increasing recognition however of the need to emphasise the process of care-giving and the interpersonal quality of patient-provider interaction (Tipping, 1995). A gender perspective also draws attention to a number of other quality of care indicators such as cultural sensitivity, and respect for users. For example insensitive hospital dress requirements, and abusive (poor attitudes and interpersonal skills) treatment by midwives deter women from seeking hospital care in childbirth. ‘Social distance’ between health care staff and poor women can lead to poor communications, indicating lower quality of care. Poor staff attitudes are related to low morale and can be improved with training and incentives.

Community participation has been identified as having the potential to improve the quality and provision of health care services. However, as with all participatory activities, special attention is needed to the gendered nature of participation. Men’s needs and perspectives
may dominate, while those of women or the poor get left out, because they are less free to participate, or have less ‘voice’. Encouraging men’s participation in health programmes may be important to women’s health. Educating men and the wider community about signs of an emergency in labour, for example, is important so they know when to seek care.

Gender divisions of labour in the production of health care

Leslie et al (1986; 307) estimate that 75 per cent of health care takes place at household or community level, and is predominantly supplied by women. Women form a high proportion of informal and community-based health providers (e.g. community health workers, traditional birth attendants) as well as lower-level professional or ancillary staff in formal health services. Current processes of health sector reform have implications for staffing structures, incentives, skills and rewards and different levels of the health system, as well as at household level, which may act to reinforce gender divisions and biases in the provision of health care.
5. IMPLICATIONS FOR POLICY OF A GENDER EQUALITY PERSPECTIVE

A range of implications for policy and programmes arise from a gender perspective on health and poverty:

• **Attention to women’s non-reproductive health needs:** A gender and poverty perspective highlights the need to include reproductive health as part of a broader conception of women’s health needs. Poverty lays women vulnerable to a range of health problems, some but not all associated with reproductive health. The heavy burdens and hazardous conditions which may be associated with poor women’s work increase vulnerability to a range of health problems, as does poor nutrition.

• **Non-health sector strategies:** A gender perspective on health and poverty highlights that the constraints to poor women’s access to health services are not only the result of poverty, but also of gender inequality. Non-health sector strategies are needed to address socio-economic and legal issues (e.g. legality of abortion, rights of girl child) which affect gender inequality.

• **Multi-disciplinary inputs:** There is a need for multi-disciplinary inputs in the design and implementation of health care projects in order to understand gender-specific cultural, political social and economic circumstances (DGIS, 1989).

• **Primary health care interventions** should assess the costs and benefits of interventions to women, as well as children, with particular attention to time constraints.

• **Community participation initiatives** must ensure that the perspectives of poor women are included. For example, an innovative initiative in China drew policy-makers attention to women’s perspective on health needs through the technique of photo-novella (see Box 1). In the context of the decentralisation, local health committees need to develop greater community involvement and accountability, including to women.

• **Information for household care**: As women are important providers of care at household level, it is important that they receive appropriate information on managing the most common fevers, recognising signs of severity and seeking prompt treatment (WHO 1995) particularly in situations of poverty where medical help is less likely to be sought. Studies of health care seeking behaviour in poor households also highlight the importance of educating men as well as women about health issues. This may be especially significant in poor households in improving the information on which decisions to seek care are based.

• **Focus on quality of care:** Studies show that perceived quality of care is a particularly important factor in decisions to seek care especially when charges are introduced. There is a need to incorporate patient management, care giving and interpersonal patient-provider relationships into quality of care assessments and improvements. Both professional and users assessments should be used to give comprehensive picture of quality and perceptions of quality (e.g. Tipping, 1994: 23). There is also a need for qualitative assessment methods which encourage women users in particular to describe their experience of health services (Tipping 1995).
• **Services convenient for women:** The availability of services must take into consideration time constraints which particularly affect poor women. Home visits and out of hours service provision should be available. Variations in the pressures on women’s time suggest a need for the preparation of community time budgets in order to decide when and how services should be offered.

**Box 1: Participatory methods for identifying women’s health needs: women’s photo novella in rural China**

The Ford Foundation-supported Yunnan Women’s Health and Development Program has used the innovative methodology of a photo-novella in order to:

- empower rural women to record and reflect their lives, especially their health needs, from their own point of view;
- increase their collective knowledge about women’s health status;
- inform policymakers and the broader society about health and community issues.

Photography can be used to promote the specific concerns of groups whose voices are seldom heard in the policy arena. Exhibits of the photographs in public spaces helped to garner the attention of policymakers and the media and a key advantage turns on the power of the visual image. Women of differing ages, marital status, income, ethnicity and educational background were selected by the Chinese Women’s Federation and given intensive training in the photo-novella process.

The photo novella experiment influenced policy on day care, midwifery, and girls’ education. Women’s photographs and discussions highlighted the dangers and health risks experienced by children left unsupervised in the field, while mothers engaged in heavy farm labour. As a result, a programme initiative to provide day care for toddlers emerged. Photographs also acted as a catalyst for discussion among women and policymakers about the lack of birthing assistance for women, the widespread use of instruments such as unsterilized scissors and the use of ‘sickle and tile’ to cut umbilical cords and the associated risks. A picture of a woman lying in bed with her three-day old baby after a home delivery was explained in terms of the inability of the family to afford the midwifery fee. This enabled the village women to challenge publicly the common assumption that ignorance rather than poverty prevented mothers from taking advantage of midwifery services. The discussion shed light on the provincial and county MCH bureaux’ responsibility to provide midwifery training, services and know-how. The photograph and discussion served to define the situation from rural women’s point of view and to identify gaps in services.

Source: Wang, Burris and Ping, 1996
6. NEW DIRECTIONS: AREAS FOR FURTHER RESEARCH/POLICY DEVELOPMENT

The analysis here highlights a number of possible areas where further research could inform new directions in integrating gender, poverty and health concerns:

**Gender disaggregated data:** Currently in health systems writing there is limited disaggregation of data by gender, thus it is not possible to say whether improved access for the poor or for disadvantaged regions translates into equal improvement for women and men. There is a real need for more gender disaggregated data (Standing, 1997).

**The household production of health (HHPH) approach provides considerable potential for greater integration of gender analysis in studies of health/well-being and poverty,** and specifically on: gender differences in time and expenditure allocation in health care; and on processes of decision-making and bargaining within the household in relation to decisions to seek care.

**Research into the impact of changes in health financing specifically on poor women:** Although a considerable amount of research exists on the impact of user fees, much of this work may exclude poor women. Changes in health service provision may improve equity of access generally, but this may hide the impact on poor women. Research is also needed on feasible financing mechanisms for gender-specific health services such as obstetric care.

**The implications of current health sector reforms for gender divisions in skills training, professional status and incentives for health sector workers (formal and non-formal).** This requires further investigation in relation to its potential impact on the quality of services to women, changes in the incomes and status of health workers and the extent of household level health care.

**Lessons could be drawn from studies of utilisation and perceptions of non-formal health services** (from the perspective of both providers and users, particularly poor communities) to suggest both improvements in formal care provision and appropriate mechanisms for supporting and regulating non-formal providers.
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