The World Bank
Yak & Yeti Hotel Complex
P.O. Box 798
Kathmandu, Nepal
Telephone: ++977 1 226792
Facsimile: ++977 1 225112
www.worldbank.org.np

Understanding the Access, Demand and Utilization of Health Services by Rural Women in Nepal and their Constraints

JUNE 25, 2001

List of References

1. Human Development Report, 1999
2. Nepal, Nepal South Asia Centre, 1998, Nepal Human Development Report, Kathmandu
3. India, Regional Office for South-East Asia, World Health Organization, 2000, Women of South-East Asia, A Health Profile, New Delhi
4. Nepal, Ministry of Health/UNICEF/WHO/The Micronutrient Initiative/New ERA Ltd., 1998, Nepal Micro Nutrient Status Survey, Kathmandu
5. Nepal, National Planning Commission/UNICEF, 1998, Nepal Multiple Indicator Surveillance Fifth Cycle (March - May 1997), Kathmandu
6. Nepal, Ministry of Health, 1997, Annual Report (1998/99), Kathmandu
7. Nepal, Ministry of Health, Nepal Maternal Morbidity and Mortality Study, 1998, Kathmandu

Understanding the Access, Demand and Utilization of Health Services by Rural Women in Nepal and their Constraints

JUNE 25, 2001

Fund Provided By
Gender Innovation and Mainstreaming Fund
Human Development Sector Unit
South Asia Region, The World Bank

Acronyms

ANC	Antenatal Care
CBO	Community Based Organization
CEDAW	Convention on Elimination of All forms of Discrimination against Women
DFID	Department for International Development
FCHV	Female Community Health Volunteer
GDI	Gender Development Index
GEM	Gender Empowerment Measure
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit (German)
HDI	Human Development Index
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INGO	International Non Governmental Organization
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
PCRW	Production Credit for Rural Women
PNC	Postnatal Care
PRMGE	Poverty Reduction and Economic Management Network, Gender & Development
SASES	South Asia Regional Environment and Social Development Sector Unit
SASHD	South Asia Regional Human Development Sector Unit
STDs	Sexually Transmitting Diseases
TBA	Traditional Birth Attendant
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children Education Fund
USAID	United States Aid for International Development
VDC	Village Development Committees
WDO	Women Development Officer
WHO	World Health Organization

Table of Content

TABLES

FIGURES

Foreword

The women in Nepal face alarmingly low health status in almost every stage of their life cycle - exposed to more social, economical and nutritional risks and biases which are much more rampant in rural areas. Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Inequalities in health across population and gender arise largely as a consequence of differences in social and economic status, differential access to power and resources and the inherent traditional and cultural practices.

This study on "Understanding the Access, Demand and Utilization of Health Services by Rural Women in Nepal and their Constraints" buids on the results of past studies by examining the perceived level of access, demand and utilization of health services by rural women themselves in five ethnically and socio-economically diverse districts of Nepal. The main purpose of this study was manily to: i) increase our understanding of the social and gender factors that are impending improvments in the health of rural women and to mainstream them into our future health assisttance strategy; and ii) facilitate the formulation of gender sensitive health policies by sharing the findings out of the study with His Majesty's Government of Nepal and partner agencies.

We hope that the recommedations made out of this study have broad relevance to all interventions related to health care in Nepal, especially those programs that are meant to benefit the rural Women.

Kenichi Ohashi
Country Director for Nepal
The World Bank

Acknowledgement

This report was prepared by a team comprised of Tirtha Rana, Senior Health Specialist, Bindu Chitrakar, Team Assistant, South Asia Regional Human Development Sector Unit (SASHD), Samjhana Thapa, Senior Social Development Specialist and Krishna Thapa, Team Assistant, South Asia Regional Environment and Social Development Sector Unit (SASES). The field research and draft reporting were undertaken by SAMANATA, Institute for Social and Gender Equality and led by Abha Darshan Shrestha and her team. This report was reviewed and edited by Ms. Lalarukh Faiz, a public health specialist.

This study would not have been possible without financial assistance from the "Gender Innovation and Mainstreaming Fund" of the Gender and Development Thematic Group of the World Bank.

We would also like to extend our sincere appreciation to Mmes. Karin Kapadia, SASES and Wendy E. Wakeman and Sarah Nedolast, Poverty Reduction and Economic Management Network, Gender & Development (PRMGE) for their support. We gratefully acknowledge the professional expertise of the consultants from the SAMANATA, Institute for Social and Gender Equality for carrying out the research and field work and for drafting the report. We would also like to thank Mr. Ian P. Morris, SASDH for his support.

The report has benefited substantively from the comments received during a workshop held on June 13, 2001 where the draft report was discussed. We would like to thank Dr. B. D. Chataut, the Director General of Department of Health Services, Ministry of Health for chairing the workshop and Dr. Chhatra Amatya, Director of Planning and Foreign Aid Division, for organizing the workshop with the World Bank.

Finally, we would like to express our profound gratitude to the key informants, community health workers and the 688 women in the study districts of Lalitpur, Sindhupalchowk, Rupandehi, Kailali and Dadeldhura of Nepal for participating in the study.

1. Background

1.1 Nepal was ranked 144 out of 174 on the 1999 Human Development Index (HDI) ***(Table 1.1)***, indicating a low level of human development as measured by life expectancy, educational attainment and adjusted income[1]. The highly patriarchal nature of the society is reflected by the country's extremely low ranking (121 out of 143) on the Gender Development Index (GDI) ***(Table 1.1)***, a measure of gender disparity in human capabilities that is used to monitor progress towards achievement of gender equality[1]. This is lower than Bhutan (119), India (112), and Sri Lanka (76) but higher than Bangladesh (123)[1]. Similarly, the Gender Empowerment Measure (GEM), representing the participation of women in economic, political, and professional spheres, is very low at 0.19[2]. The GEM values for Bangladesh, India and Sri Lanka are 0.30, 0.24 and 0.32 respectively[1]. Female life expectancy at birth is 57.1 years, lower than that in Bangladesh, Bhutan, India and Sri Lanka (58.2,62,62.9 and 75.4 respectively)[1]. The female adult literacy rate is 20.7 percent, lower than that of Bangladesh, Bhutan, India and Sri Lanka (27.4,30.3,39.4 and 87.6 respectively)[1] ***(Table 1.1)***.

Table 1.1 Regional comparison of Human Development Indicators

Country	HDI global ranking 1999*	GDI global ranking 1999*	GEM global ranking 1999*	MMR Per 100, 000 (In live births)+		IMR per 1000 live births, 1997*	Life Expectancy 1997*		Female Literacy Rate 1997*
					Year		Female	Male	
Bangladesh	150	123	0.30	449	1994	81	58.2	58.1	27.4
Bhutan	145	119	..	380	1994	87	62.0	59.5	30.3
India	132	112	0.24	408	1997	71	62.9	62.3	39.4
Nepal	144	121	0.19**	539	1990-1996	75	57.1	57.6	**20.7 (32.9 as of 2001) ++**
Sri Lanka	90	76	0.32	24	1995	17	75.4	70.9	87.6

*Source: * Human Development Report, 1999. ** Nepal Human Development Report, 1998 (value from 1996) +Women of South-East Asia, A Health Profile, WHO, 2000, ++Basic Social Service Study: Analysis of Social Sector Development, National Planning Commission and UNICEF, 2001*

1.2 The infant and maternal mortality rates in Nepal are among the highest in the world at 75/1,000 live births[1] and 539/100,000 live births respectively[3]. About seventy percent of women of reproductive age are anemic and malnourished[4]. Women face harsh conditions during pregnancy and childbirth. Many women get pregnant at a young age and do not leave adequate space between children[5]. Furthermore, many are forced to do hard labor during pregnancy. Together, these factors have a negative effect on intrauterine growth and the development of the fetus, resulting in underweight infants who are vulnerable to infections.

1.3 Most women lack access to basic maternity care. Only 27 percent of women seek antenatal care once during pregnancy[6]. Of those that seek prenatal care, the average number of ANC visits per pregnancy is 1.8, far short of the minimum of four visits per pregnancy that are required[6]. According to a 1997 survey, a little over a third of surveyed women (34 percent) said that they did not receive ANC because they thought they did not need it. Thirty-one percent said that they did not traditionally receive antenatal care. Twenty four percent of women said they did not know that such services were available. Eleven percent said the health facilities were located too far away and five percent did not have enough money to pay for the services. Two percent of the women did not have time to visit a health facility; two percent said their family members did not allow them to seek care and two percent said they did not seek care because the service was poor[5i]. As for childbirth, most deliveries occurred at home in unsafe conditions. Only 8 percent of births take place at health facilities and only 13.4 percent of births are attended by trained health personnel[6]. After childbirth, 9 percent of women seek postnatal care[6].

1.4 Figures 1 and 2 corroborate the above findings. Most maternal deaths occur at home (68%) due to a number of factors that could be prevented with skilled and timely attendance during pregnancy and child delivery.

1.5 Despite the fact that the availability of public health services has increased throughout the country, health services are still beyond the reach of most rural women. It is reported that only 45 percent of households have access to basic health care[5]. Very little research exists in Nepal that addresses the cultural and socio-economic factors that limit women's access to health care. Two recent studies have examined this issue: Focus Group Study on Reproductive Health in Nepal from Socio-Cultural Perspective (UNFPA, 1999) and Health Seeking Behavior of Women in Five Safe Motherhood Districts in Nepal (UNICEF, 1998). While the latter study focuses

[i] *Values are not mutually exclusive. Women were allowed up to three responses.*

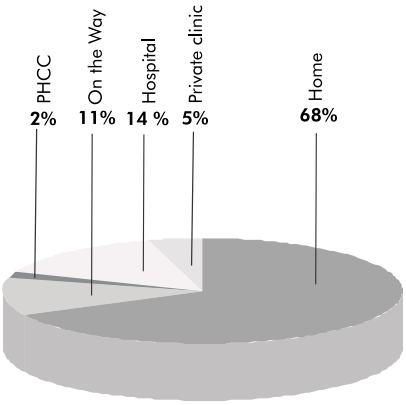


Figure 1: Place of maternal deaths

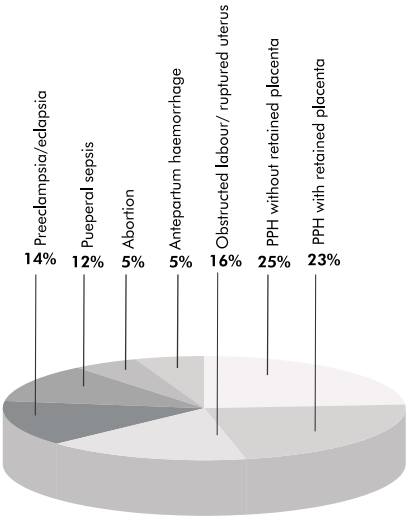


Figure 2: Direct cause of community maternal death(n=93)

Source: Figure 1 and Figure 2 - Maternal Mortality and Morbidity Study, 1998

on pregnancy and delivery related issues, the first investigated a broader range of reproductive health concerns. Both studies found gender discrimination, position of women in the family, and lack of self-worthiness among women to be important factors influencing their health care seeking behavior.

1.6 This World Bank study builds on the results of past studies by examining the perceived level of access, demand, and utilization of health services by rural women in five ethnically and socio-economically diverse districts of Nepal. The researchers attempt to determine why under-utilization of services exists despite the high need for health services and the existence of an expansive network of over 4000 outreach level public health facilities[6].

Goals and Objectives

1.7 The goals of the study are:

- To increase our understanding of the social and gender factors that are impeding improvements in the health of rural women and to mainstream them into our future health assistance strategy.
- To facilitate the formulation of gender sensitive health policies by sharing the findings of this study with partner agencies and key decision makers in the health sector.

1.8 The objectives of the study are to:

- Investigate constraints that prevent poor, rural women in Nepal from demanding, accessing and utilizing health services.
- Examine the social and gender issues that influence poor health seeking behavior in order to understand what factors need to be addressed at the community, district and national levels.
- Examine existing policies and programmatic factors that prevent women from accessing care.

Methodology

1.9 Information was gathered from primary and secondary sources from February to June 2001. Primary information was

gathered from questionnaires, focus group discussions and interviews with key informants at the household, community and central levels. Secondary information was generated from published documents.

1.10 Districts were selected according to several factors including geographical region, ethnic composition, socio-economic characteristics and available health institutions and services. The districts chosen were Lalitpur, Sindhupalchowk, Rupandehi, Kailali and Dadeldhura ***(see Map)***. The constituency of the districts represent a variety of ethnic groups: Newar; Magar, Gurung, Rai and Tamang; Yadav and Ahir; Damai, Sarki and Kami; Brahman and Chhetri.

1.11 The selection of village development committees (VDCs) was based on: i) existence of the Production Credit for Rural Women (PCRW) program, and ii) distance from the health facility. It was assumed that members of the PCRW program would be more knowledgeable and informed about diseases and more likely to seek health care than non-members. They are termed as the seekers while other women are termed as non-seekers. One VDC where the PCRW program was being implemented was within two hours travel time of the nearest health service facility while the other was more than two hours travel time from the nearest health facility. The hypothesis was that when people have to travel for more than two hours to a health facility, they would be less likely to visit the health facility due to time restraints, transportation costs, etc. The staff of the Women Development Section in the district assisted in identification of the VDCs. Ten VDCs were selected for the study, two in each of the five districts. Focus group discussions were held in the each of these VDCs.

1.12 The Women Development Officers (WDOs) and local community workers assisted in the selection of focus group participants. The selection of participants for

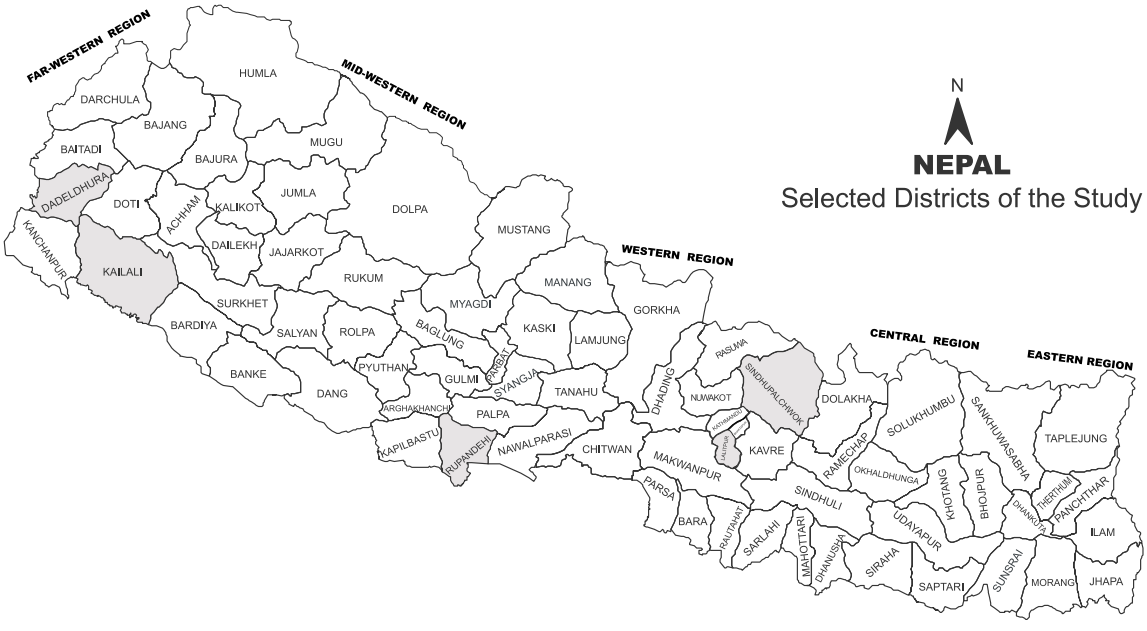
Table 1.2: Data Collection Scenario by District

VDC-1 within two hours travel to the nearest health facility and VDC-2 more than two hours travel to the nearest health facility											
In each VDC selection of PCRW members (seekers) and non-members											
VDC - 1						VDC - 2					
Seekers in Years			Non-Seekers in Years			Seekers in Years			Non-Seekers in Years		
<18	19-35	>35	<18	19-35	>35	<18	19-35	>35	<18	19-35	>35
3 focus group discussions			3 focus group discussions			3 focus group discussions			3 focus group discussions		
Total focus group discussions = 12											

focus group discussions was guided by the three age groupings used in the UNICEF and UNFPA studies mentioned above. Group 1 consisted of women 18 years of age and under; Group 2, women 19-35 years of age and Group 3; women above 35 years of age ***(Table 1.2)***.

1.13 Twelve participants, 6 married and 6 unmarried women, were chosen to participate in the focus group discussions at each of the 10 selected sites. In all 720 women were expected to participate in 60 focus group discussions but only 688 women participated because the number of respondents under 19 years of age in Rupandehi was lower than expected. ***Table 1.3*** shows the actual number of participants in the focus group discussions categorized by distance from health facility, membership in the PCRW program and age group.

1.14 Qualitative information was gathered from focus groups discussions and interviews using checklists and guidelines developed by the researchers. At the central level information was gathered by interviewing key personnel in the Ministry of Health, Department of Health Services and National Planning Commission (key informants). At the rural community level, information was gathered through focus group discussions comprised of local women, community health care service providers, female community health volunteers, traditional birth attendants and informal interviews with service providers at health facilities (key informants).



1.15 Each focus group participant also filled out a questionnaire, which in effect quantified some of the qualitative responses given in the discussions.

1.16 Preparation for the field visits included orientation and training for the entire survey team organized by the consultants assigned to the study. The questionnaire, tools and techniques pre-tested in Chapagaon of the Lalitpur District. In the field, five teams of two research officers gathered data and information, one in each district. Inventory appraisals of the health service facilities were also conducted.

Table 1.3: Respondents by Distance from Health Facility, Health Care Seekers/Non-Seekers and Age Groups

Districts	Distance from Health Facility		Health Care		By Age Groups		
	Near	Far	Seeker	Non-Seeker	19 Yrs	19-35 Yrs	>35 Yrs
Lalitpur	72	72	72	72	48	48	48
Dadeldhura	72	72	72	72	48	48	48
Sindhupalchwok	72	72	72	72	48	48	48
Kailali	72	72	72	72	48	48	48
Rupendehi	54	58	53	58	16	48	48
Total 688	342	346	341	347	208	240	240

2. General Findings at the Community Level

2.1 It was assumed that there would be some difference in the level of demand, access and utilization of health services among care-seekers and non-seekers. However, this was not the case. This was probably due to methodological problems related to the selection of VDCs. VDCs were selected only on the basis of presence of the PCRW program and distance from the health facility. Factors such as availability of local transportation, average income level of the community, and status of the PCRW program were not taken into account, so the constituency of the VDCs were perhaps more homogenous than expected.

2.2 Lack of knowledge about illnesses

Women could describe only obvious symptoms of their illness such as headaches, fevers, joint aches and body aches. They were more knowledgeable about pregnancy and delivery related problems than illnesses such as tuberculosis, malaria and typhoid. This lack of knowledge contributed to their delay in seeking care.

2.3 Lack of decision making power and inability to pay

The majority of women would consult family members, usually the head of the household and /or whoever controlled the cash/family finances before seeking care. Approximately half (51.2 percent) of women consulted their husbands. 44.5 percent consulted family members such as their mother in law or sister in law and 3 percent consulted neighbors and friends. Women who earned money through self-employment or PCRW credit sometimes used the small amount of money they earned to pay for health care, but most women would only seek care on their own accord if services were free.

2.4 Disregard for illnesses

In all districts women were recognized to be ill by family members only when they were bedridden or unable to perform their daily tasks. The women felt that most illnesses would get cured by themselves. Those who sought care for general illnesses first tried home medicine. If this was not successful, they visited traditional healers. If they were still sick, those who were able to access care would then visit the nearest health facility, usually the health post, followed by the hospital, sub-health post, private medical shops and clinics and NGO facilities. When girls under 18 were sick, they informed their mothers about their illness but hesitated to visit health facilities if they needed gynecological or family planning services. They only visited the hospital if they were seriously ill.

2.5 Unwillingness to disclose illnesses

Women did not disclose symptoms such as vaginal discharge due to shyness or illnesses such as tuberculosis and leprosy due to fear of being ostracized by family members and the community.

2.6 Low value given to women's lives

Family members and women themselves place a very low value on women's lives, thus women's health is often ignored.

2.7 Distance from health facility

Some women were unable to access care due to distance to health facility and lack of a means of transportation.

2.8 Lack of time

Respondents in all of the five study districts reported that lack of time due to their heavy work burden restricted them from seeking health care.

2.9 Alcoholism and Violence

Alcoholism among husbands was reported to be a problem in all districts except Dadeldhura. This limited the funds available to women to seek health care. Violence against women was reported in Lalitpur, Rupandehi and Kailali. Fear of such violence contributed to women's reluctance to voice their need for healthcare services.

2.10 Caste discrimination

Caste (for low caste women) discrimination by community members and providers restricts certain women from accessing health care services.

2.11 Presence of female health services providers

In all of the five study districts, the absence of female health service providers inhibited women from visiting the health service facilities. Women were reluctant to consult male health workers especially when a gynecological examination was required. Most of the time, assigned health service providers were absent from the health posts and only peons and clerks were available to provide services. This was particularly true in the hill districts of Sindhupalchok and Dadeldhura where the health facilities were less accessible.

2.12 Age

Women over 35 years of age were in a better position to access health care because they were more empowered to voice their needs and had more control over family resources.

2.13 Education

Increased education of women and their husbands was positively correlated with increased utilization of all health services.

2.14 ANC and PNC services

The proportion of those reporting to have utilized antenatal care was higher than those who used delivery and postnatal services. Women who discussed their health problems with their husbands were found more likely to use ANC, delivery and PNC services. Women from nuclear families were more likely to use ANC, delivery and PNC services than women who belonged to a joint family. Those women who engaged in self-employed agricultural work were more also likely to use such services.

2.15 Level of satisfaction with health services

Of the women visiting the health facilities just over one third (35.6 percent) of them reported full satisfaction with the services they received. The causes of

dissatisfaction with the health care received were perceived inaccurate diagnosis of the disease, inadequate supply of medicines, and absence of skilled service providers.

2.16 Flow of information

There is inadequate interaction and flow of information between service providers, clients and local community based organizations (CBO's). This has significantly constrained service demand, access and utilization.

3. Findings Related to Policy and Programmatic Factors

3.1 Lack of understanding of gender concepts at the policy and planning levels

Although the Government ratified its full commitment to women's development and advancement in the CEDAW, ICPD and Beijing Platform of Action, their actions have not adequately backed their commitment. In the Ministry of Health, we noted that a general impression exists that all the needs of woman are being addressed through various safe motherhood and reproductive health programs. In reality, this is not the case. Aside from such programs, the same services are provided for males and females without specific provisions to suit women's different biological needs and without addressing the critical social and economic factors that limit women's access of healthcare.

3.2 Inadequate political commitment

There is not adequate political commitment to understand and lift gender related impediments that limit women's access to healthcare. At the service delivery level, insufficient mechanisms are in place to enhance the role of female community health volunteers, traditional birth attendants, local mothers' groups, users' groups of other sectors, health facility support committees and local community members, so they can better support women's health.

3.3 Missing data in HMIS

There is a lack of gender dissaggregated data in the health management information system of the MOH to guide the development and assessment of health policies, plans and programs.

3.4 While reviewing the records of the health facilities, it was found that data was collected about patients' sex, age and illness, but not by ethnic group. The recorded gender disaggregated data was found not incorporated in the regular HMIS reporting.

3.5 Non-health factors constraining women's access, demand and utilization of health care, such as their socio-economic status and cultural factors are not included as indicators in the existing information system. Adhoc small-scale studies conducted by donors on safe motherhood and reproductive health have included such data, but it has not been fully considered by policy makers while designing health programs. For example, inadequate action has been taken concerning the three critical delays that occur during child delivery and significantly contribute to higher levels of maternal mortality: i) delay in decision-making at the household level to take the women in labour to health facilities, ii) delay in transportation to the health facility, and iii) delay in receiving care at the health facility level[7].

3.6 Lack of community representation

At the district level, no mechanism is in place to guarantee community representation in the planning process according to caste, class and gender, or to receive feedback from service users regarding quality, quantity and appropriateness of services provided.

3.7 Lack of knowledge/control over resources

More than 50 percent of the development budget in the health sector comes from external sources and most of aid money is managed by donor agencies. Due to this, the MOH does not have an accurate picture of expenditures of donor assisted programs. At the national level, there seems to be a consensus to increase funding for social sectors but when it comes to the actual allocation of public funds, the amount allocated for non-salaried recurrent expenditures in the health sector is not sufficient to cover the essential health care needs of the population.

3.8 Centralized budget allocation system

All major policy decisions in the health sector are based on a centralized budget allocation system and centrally decided health priorities. Programming is indirectly determined by budget allocation decisions made by the Ministry of Finance for the health sector. Thus, it appears that the MOH's capacity to negotiate with National Planning Commission, the Ministry of Finance and donor agencies is limited with respect to financing prioritized health programs and support services such as health facilities maintenance, drug supplies and integrated training of health workers. It

leaves limited provision to take into full consideration of women's overall health concerns besides safer motherhood program.

3.9 Lack of women in decision making positions

In the health sector, there are a significant number of women in the labor force. However most of them are occupying peripheral and assistant level technical positions. Very few are in managerial, programming and policy level decision making positions.

3.10 Inadequate training of health personnel

Adequate training opportunities to peripheral level health workers with regard to women's health needs and non-health factors that limit their health seeking behavior are not provided. Protocols, manuals and guidelines regarding data management, diagnostic capability and proper counseling including supportive supervision and monitoring to enhance the quality of care are not adequate.

3.11 Inadequate staff and medical supplies affect services provided

Retention of core health staff at the level of health facilities due to lack of motivation - especially women - is a major concern. Most of the time, midwives and MCH workers are absent in the health posts and sub-health posts limiting the availability of critical safe motherhood and reproductive health related services.

4. Recommendations

4.1 This study identified several factors that limit women's demand, access and utilization of health services. Socio-economic and cultural factors delay decisions to seek health care and limit women's ability to demand and access care. At the health facility level, systemic problems limit women's access and utilization of health care. At the national level, health policies and programs are ineffective and do not account for differences based on gender.

4.2 However, there are reasons for optimism due to the presence of: i) an expansive network of health facilities; ii) some level of awareness of health issues amongst the consumers; iii) increasing organization and mobilization of user groups at the community level to permit a structured dialogue with users, provided that service providers increase their efforts; iv) a mechanism to pool resources including contribution from service users through expansive introduction of community drug

programs and various health insurance schemes, thereby increasing women's capacity to demand services; and v) a slightly better understanding of importance of gender mainstreaming in health among policy makers and program managers. Taking all these facts into consideration, a set of detailed recommendations are given below.

At community level

4.3 Increase knowledge regarding women's health

Increased knowledge and awareness of women's health needs must be provided to women including their spouses and family members. Awareness and sensitization about communicable diseases such as HIV/AIDS, STDs, tuberculosis and leprosy must also be increased in order to end the stigma attached to such diseases. Adolescents should have access to sexual and reproductive health education starting at an early age. This can be done using IEC materials, interpersonal consultations such as literacy classes and mother's group meetings, school and adult health programs and local campaigns.

4.4 Work with traditional faith healers and community based health workers

We must help build the capacity of traditional healers and FCHVs to identify the risk factors of the major diseases affecting women and children, relay information about the importance of preventive actions, immunization, ANC, safe delivery and PNC care, stress the importance of adopting safe sex practices to avoid HIV/AIDS and STDs, motivate women to visit health facilities and ensure timely referral to appropriate health facilities.

4.5 Participation of women in health management

Active participation of local women in community based health service management, particularly TBAs and FCHVs is necessary. Existing women's groups such as micro-credit groups, mother's groups, community forestry user groups, water/sanitation user groups, and religious groups must be mobilized to advocate for the incorporation of local health needs into health policies and programs. In places where women's groups are non-existent, women should be facilitated and encouraged to express their health concerns through periodical consultations with the existing local organized groups.

4.6 Provide quality care

Skilled staff and necessary medications, supplies and necessary counseling must be available at health facilities. Care must be provided in a sanitary environment while maintaining the privacy during physical examination and counseling. Women should have access to confidential, sexual and reproductive health services including private counseling on HIV/AIDS and STD's. Health professionals should be educated on human rights and gender-sensitive care. All private and public health institutions should be required to treat patients irrespective of ethnicity or gender. Women's time spent with the health care provider should be minimized and health care institutions should be more flexible service hours convenient to women.

4.7 Employ local women as health service providers

Women from local areas should be encouraged to serve as service providers in order to improve the retention rate of providers and ensure the availability of female health care personnel. In the beginning, such a cadre should be recruited based on a reserved quota for remote districts. They should have opportunities for career advancement and incentives based on performance.

4.8 Strengthen and institutionalize referral health services

Systems and mechanisms including provision of transportation that strengthen the referral system should be supported, particularly for critical cases. Local level organization should be maximally mobilized to improve the referral system.

4.9 Improve status of women

Women should be empowered through education, and credit/income generating programs. A village level initiative supported by local I/NGOs could be started to provide a revolving fund at the VDC level for use by women who need to seek health care services. Existing micro-finance programs could include a women's health component focused on compulsory health insurance financed from the participants' savings. This would enhance women's ability to access and utilize health services.

4.10 Ensure that women's needs are considered

A mechanism must be created to ensure that women's health needs are reflected in health policy through a participatory bottom-up approach. This is possible through interactions and consultations between responsible authorities at all levels and local women; coordination between the MOH and other concerning ministries; interaction between the MOH and INGOs/ NGO and CBOs, that are already working with women; and the development of implementation strategies to enable local health facilities and NGOs and CBOs to work together.

At the institutional level

4.11 Advocacy and commitment

Advocacy should promote gender sensitive health policies in order to improve women's access to and control over resources, enhance their decision making power and meet their critical health needs. Health related legal provisions such as increasing the age at marriage must be enforced and assuring measures against domestic violence. Additionally, advocacy should be much more geared towards making the state accountable to its commitments regarding women's health. We must continue to boost these efforts and raise awareness of the critical links between poverty, gender inequality and the poor health outcomes of women and the overall population among political bodies and relevant government officials, NGOs, and academic institutions.

4.12 Develop gender awareness among high-ranking officials

Efforts are beginning to provide gender sensitization sessions to high level bureaucrats, political bodies and program managers. There is much more dialogue and discussion among governmental agencies with regard to gender mainstreaming than earlier. Multi-lateral governmental agencies such as UNDP, UNFPA, WHO and bilateral agencies such as USAID, GTZ, and DFID are actively supporting sectoral ministries to implement gender sensitive initiatives. WHO has provided technical assistance to the Ministry of Health to update the Women in Health and Development Report of Nepal that will elaborate on gender related concerns specific to health policy and planning, program design and implementation and overall gender mainstreaming in health system.

4.13 Need for increased number of women in decision making positions

There is a need for a critical mass of women in policy/planning/executive levels, i.e. more women in decision making positions. Few women civil servants are currently provided with the opportunity to hold such positions.

4.14 Need for gender and health experts

A critical mass of gender and health experts must be trained at the Ministry of Health to integrate gender related matters in health training curriculum and provide training of trainers. These experts should routinely carry out gender and socio-economic analysis in all new and existing health policies and programs and incorporate necessary provisions to ensure that women's concern for complete health needs are satisfied.

4.15 Intersectoral coordination

There is a critical need for intersectoral coordination at the central, district and local levels. This will help ensure that provisions are made to address women's health needs through all relevant sectoral inputs such as education, micro-credit program for health promotion.

4.16 Encourage further research

Governments should encourage further social and anthropological research in order to evaluate the needs of women, the factors influencing their health seeking behavior and the degree of satisfaction with the services provided. Health policies and programs should be formulated and implemented based on such evidence-based research. Necessary networking and coordination of research work in regard to women's health and gender mainstreaming that are carried out by various agencies should be made available to use for policy and program update.

4.17 Incorporation of local need based gender issues in health policies and plans

Location and situation specific gender issues need to be incorporated in health policies and plans. Since women's health needs and problems are diverse and differ by district due to socio-cultural, ethnic and ecological diversity, adoption of a blanket approach should be eliminated.

4.18 Generate gender and ethnicity dissaggregated data

The government should ensure that research data and service statistics are dissaggregated by age, sex and ethnicity and monitor data collection. The current health management information system needs to include gender-disaggregated data from peripheral level health facilities. New gender sensitive indicators should be developed to provide a more accurate measurement of women's health. ***(see Annex)*** Such data should be made available and used to formulate gender sensitive health policies and programs that target vulnerable groups.

4.19 Train health workers

Government, donor organizations, and INGOs/NGOs should provide training and support to ensure that the health workers adopt a gender sensitive and socially conscious attitude towards their patients and client. They should be regularly trained and updated on life saving skills.

4.20 Provide health workers with adequate emergency supplies

Peripheral female health care workers should be provided and refurbished with a first aid kit and a safe home delivery kit so that they can provide emergency care.

4.21 Availability of gender sensitive health information, education and communication (IEC) tools

Effective IEC tools need to be designed to suit local cultural practices, health issues and social norms. Existing health IEC materials should be reviewed for their level of gender sensitivity and updated accordingly. Such materials must also stress ways to avoid the three critical delays in seeking care. In addition the health care providers need skill building in inter-personal communication technique and counseling.

Annex

1. Examples of gender-sensitive indicators

- Percentage of government expenditure devoted to women's health needs in a) productive and b) non-productive areas
- Percentage of budget support allocated for gender priorities
- Percentage of female health personnel at the different levels of the health system
- Percentage of female health personnel in managerial and professional posts.
- Percentage of female health personnel in training opportunities (overseas, pre-service and in-service)
- Salary/wage differentials of women/men by class of workers
- Number of/access to primary health care centers by sex
- Number of visits to and number of bed-nights spent in hospital by women/men; number of hospital beds as percentage of population
- Proportion of girls and boys immunized against specific diseases
- Proportion of births attended by a physician, midwife or trained auxiliary
- Mortality and length of life, by sex
- Maternal mortality rates (per 100,000 live births)
- Infant mortality rates and female/male ratio
- Number and/or incidence of selected communicable diseases of public health importance including AIDS, by sex
- Percentage of women's/men's incomes spent on food
- Access to sanitation and clean water by sex
- Percentage of women's/men's girls'/boys' injuries by type of incident/accident

2. Gender-sensitive questions that address gender differentials in health

- What percentage of health personnel are women, at the different levels of the health system?
- How are gender disparities among health professionals addressed?
- Has the health personnel understood and accepted gender inequality and gender relations as factors that influence individual's health and the quality of health services?

- What cultural and other obstacles are there to women and girls receiving health care and family planning services?
- Is abortion legal? What are the services available in practice?
- Is intra-household distribution of food biased against women and girls? If so, what are the reasons for this?
- Does access to sanitation and clean water differ by sex? If so, what are the implications of this for women's health?
- What are types of violence experienced by women and men?
- What cultural definitions influence to identify the gender risks in violent and conflict situations?
- What are the most recurrent self-destructive tendencies for men and women?

3. Stakeholders involvement

- Who are the stakeholders?
- What mechanisms exist to involve primary stakeholders in the health sector and in the specific health programs?
- What are the established gender roles and how do they affect gender differences in incidence, early detection, health seeking behavior, use of health services and compliance?
- Which policy and program initiatives exist to meet the needs of specific groups (children, adolescents, men, women, elderly, displaced, disabled, etc.) in the health sector?

4. Social Inclusion

Questions to identify marginalised groups

- Who are the powerless groups that are particularly discriminated against and how does such discrimination or lack of power affect their health?
- Does resistance exist to improve the inclusion of marginalised groups?
- What disparities affect differently the health and well-being of men and women, boys and girls?
- Which disparities exist between different social groups and between women and men within those groups?
- Do women need permission from their husbands, fathers, mother-in-laws, brothers or others to use health services?
- Does resistance exists to change damaging gender stereotypes that result in health disparities between men and women?

Source: Using Gender-Sensitive Indicators, Gender Management System Series, Commonwealth Secretariat, 1999