


CASE STUDY

Influence of Changing Gender and Social Norms on Health Seeking Behaviour and Health Systems in Cities

INTRODUCTION

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Community-led Responsive and Effective Urban Heath System (CHORUS), an international Research Programme Consortium, participated in the 18th International Conference on Urban Health held in 24-27 October in Valencia, Spain. The 2022 conference theme was 'Growing our Global Community. Driving Action. Ensuring Equity'. The goal of the conference was to connect all global stakeholders working within the urban health domain to promote action and ensure equity across cities and regions.

The CHORUS team from Bangladesh, Nepal, Nigeria, Ghana and UK participated in five conference sessions. This case study is based on one of the sessions titled 'How are Changing Gender and Social Norms Influencing Health Seeking Behaviour and Health Systems in Cities in West Africa and South Asia?'. The session was chaired by Prof. Helen Elsey, University of York and presentations were provided by Dr Lauren J. Wallace, University of Ghana; Sushama Kanan, ARK Foundation, Bangladesh; Dr. Chinyere Mbachu, University of Nigeria and Abriti Arjyal, HERD International, Nepal.

Presentations included early findings from the CHORUS needs assessment qualitative methods such as individual interviews and participatory transect walks with residents of different genders and health providers in urban poor neighbourhoods and local stakeholders. The discussion emphasised how gender interacts with other social stratifies to affect health-seeking behaviour in underdeveloped urban areas, and looked at the similarities and differences between countries to draw up recommendations for how to improve urban health systems and foster equitable urban settings.

In recent years, urban health systems have been characterised by a growing plurality of healthcare providers, from both the formal and informal sectors. The formal health care providers include public hospitals, private hospitals and clinics, while the informal healthcare providers include drug stores and traditional healers. This phenomenon is driven by a range of factors, including urbanisation, demographic changes, less effective regulation and coordination of services, fragmentation of the health system and the increasing demand for health care services. As a result, many cities around the world are now home to a large range of providers.

There is a need to invest in public health care providers, particularly in low-income areas where public providers are often the main source of care for the population, as this can help to ensure that all individuals, regardless of their income or social status, have access to high-quality healthcare services.

All four countries used a framework developed by Morgan, et.al. (2016) to guide the analysis. The framework has a focus on understanding gender power relations among several social strata, and the process of power negotiations and changes, including who has what (access to resources); who does what (the division of labour and everyday practices); how values are defined (social norms) and who decides (rules and decision-making).

KEY MESSAGE FROM FOUR COUNTRIES

NEPAL

In Pokhara Metropolitan City, urban poor residents were found visiting different health service providers to seek health care. The decision for care seeking was influenced by multiple factors including gender, occupation and income of urban poor.

It was found that the decision making involved discussion at the family level, but often the final decision was made by the head of household who in most cases were male. Women were more involved in care giving and supporting the family member to visit the health provider. In some cases, despite having the capacity to take decisions for seeking health services, they still prefer to take permission from their husband or in-laws.

A female participant from Focus Group Discussion (FGD) said, "*Mainly husband takes the decision. In the absence of my husband, I decide.*"

In the city context, most urban poor are daily wages labourers and their time availability is limited. In such situations, although women and men preferred the government health facilities, as the basic health services are available free of cost, inconvenient opening hours discouraged them to access their services. As a result, female daily-wage earners were ready to pay more if facilities such as pharmacies were accessible and open at a time that allowed them to reach work even if the same services are available at free of cost in the government facilities.

A key Informant shared, "*Some people may have to reach to their work at 10am and the government health facilities open at 10am. And to come to the health facility it takes time. For taking one Depo-Provera injection they would need to spend a day which means their 500 to 600 Nepali Rupees is lost because they are unable to reach to their work on time*".

In addition, wider societal gender norms see women taking on the dual responsibility of earning an income and carrying out all the domestic chores, and taking care of the family members determined the service choices. A woman from a poor urban community said, "*I take my child to the private clinic first; I take him to the government hospital for serious illness only. The government hospital is far and it takes up my whole day if I go there.*"

BANGLADESH

The needs assessment of the study conducted in Dhaka (Dhaka North City Corporation) found that the urban primary care services focused on maternal, sexual and reproductive health. So, male patients do not visit these centres for their own primary healthcare needs, rather they prefer to visit their known pharmacy, especially with a private chamber of doctor. They also depend on home remedies. If men do go to the primary care services, the workforce is predominately female; the lack of male counsellors or doctors may also explain why so few men attend the primary care facilities.

A female health care provider said, "as we provide more services for mother and child, and female patients prefer female health worker to visit, so you will find more female health care provider."

In a reinforcing cycle this means that centres do not recruit male health workers. The low salaries in the clinics run by Non-Government Organisations (NGOs) also mean that male health workers are not interested to work in these centres. Thus, the gender disparities impact on service providers as well as clients; a female health facility manager we interviewed said, "*We cannot retain male health service provider much, you know. Because our salary structure is poor and with each term it decreases. So, men are not interested to continue working with this amount.*"

The opening times of these centres (9am - 4pm) is not easily accessible as men in these slum areas are busy with their work at this time, particularly given the long queues and waiting times at NGO clinics. A male community member told us he does not visit the clinic for two reasons, first he has to pay for the service and second, he loses earning for the day if he visits the clinic.

The transgender community within the city face particular discrimination at the health centres. They reported that health centre staff had told them they should not attend as it will upset the other patients, and they were afraid their presence would lead to disputes and arguments if transgender patients were in the same waiting room. As a result they are often told to come back at the end of the clinic time or are deprived of treatment.

A member of this gender minority community shared, "*If we ever enter a hospital or clinic, the behaviour of the doctors, nurses and other staff [makes us] feel very uncomfortable. We are often asked in a harsh and unwelcoming tone why we visited the clinic and they also ask to come last of all.*"

The respondents preferred to use the pharmacies that are near to the slum areas where they live as they know the pharmacy owners and they looked empathetic towards the problems of the visitors with third gender status.

GHANA

A key strategy of Ghana's approach to ensuring equity in access to Primary Healthcare is the Community based Health Planning and Services (CHPS) Programme. CHPS places nurses, also called Community Health Officers (CHOs) within specific zones to provide a basic package of services delivered through outreach service points called CHPS compounds. The CHOs are also engaged in home visiting and community education with support from community volunteers. The CHPS program should engage people of all genders throughout the life course. However, in urban areas, the provision of the full package of services is curtailed due to resource challenges, including inadequate staff and logistics.

Home visiting and community education is limited with more focus placed on immunization and child welfare. As a result, the CHPS program as it is delivered in urban settings engages predominantly women and their children, with less focus on men and older persons.

"*Right now you see that the sun is on you right now and you need to move back. We need a place. We need BP apparatus and things to work with to do our normal activities*" a female community health nurse explained, "*And the distance, for home visiting, we need a car, or transport allowance; the government didn't say that the salary that you are taking should be used for transport to do outreach.*"

In the urban communities in Ashaiman and La-Nkwantanang Madina Municipalities in Greater Accra, where CHORUS Ghana works, the health problems faced by residents are also gendered. While both men and women experience malaria and diarrheal diseases due to the unclean environments where they live, women are more likely to be exposed to unwanted pregnancy and Sexually Transmitted Infections (STIs) due to their gender and their roles in sex work. Men are especially vulnerable to workplace injuries (due to their engagement in jobs such as mechanics and metal works) and they also experience higher rates of drug abuse. Both women and men prefer to visit pharmacies or chemical shops for minor illnesses since they offer shorter waiting times and are less expensive than visiting public or private clinics or hospitals.

A male staff member of a pharmacy in Taifa, Ashaiman said, "*Some people, for them if they think it is malaria, they just get Rooter mixture, because they have been seeing that it works, they do not have time to go to the hospital.*"

NIGERIA

The changing roles of men and women in household provisioning means that in addition to being the primary caregivers in the household, income-earning women in urban slums are taking on more roles in decision making (and paying) for health seeking. Women's decisions about health care seeking are influenced by the conventional supply and demand factors such as ease of access to health services and the attitude of service providers. Health seeking is also affected by intangible values such as superstitious or diabolical beliefs about illness causation or cure, and family norms that are passed down from generation to generation of mothers. For the latter reason, informal providers such as traditional healers and birth attendants are often consulted for health services in urban slums.

There are variations in the pattern of healthcare seeking among women in urban slums in Enugu state on the basis of privilege such as access and resources. The more privilege a woman has, the more she is likely to access quality health services. For instance, the single woman who has tertiary education and is employed will not patronize a 'chemist' because she can afford to pay for laboratory investigations and the services of a medical doctor. Whereas the one who has the same level of education but is unemployed would consider a 'chemist' if the symptoms are mild and the illness is short-lived.

"*The chemists are more easily accessible because it's close by and it's very cheap. For instance, if you have a headache you won't go to the hospital, you'd go to a chemist to get paracetamol*," an unemployed single female with tertiary education said, "*If the headache persists after two or three days then you go to the hospital.*"

CONCLUSION

Our research has highlighted how the organisation and delivery of primary health care in cities interacts with gender dynamics to influence the health seeking behaviours of men, women and sexual minorities. Several factors were identified across the city contexts that limited male use of primary healthcare. In particular, the gendered hierarchy within the health workforce is clearly illustrated. In cities in four contexts, primary health care is primarily delivered by women. The resultant lack of male health workers along with the inadequate provision of services beyond maternal and child health limits male access to primary care. The urban poor of all genders predominantly rely on informal, daily-wage work and this necessitates long working hours. Health facilities that open for only a few hours during the working day are clearly not accessible to these workers. The stories of transgender people are rarely told and their experiences highlight how it is not just opening times and type of care that restrict access, but the stigma and discrimination they experience from staff.

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