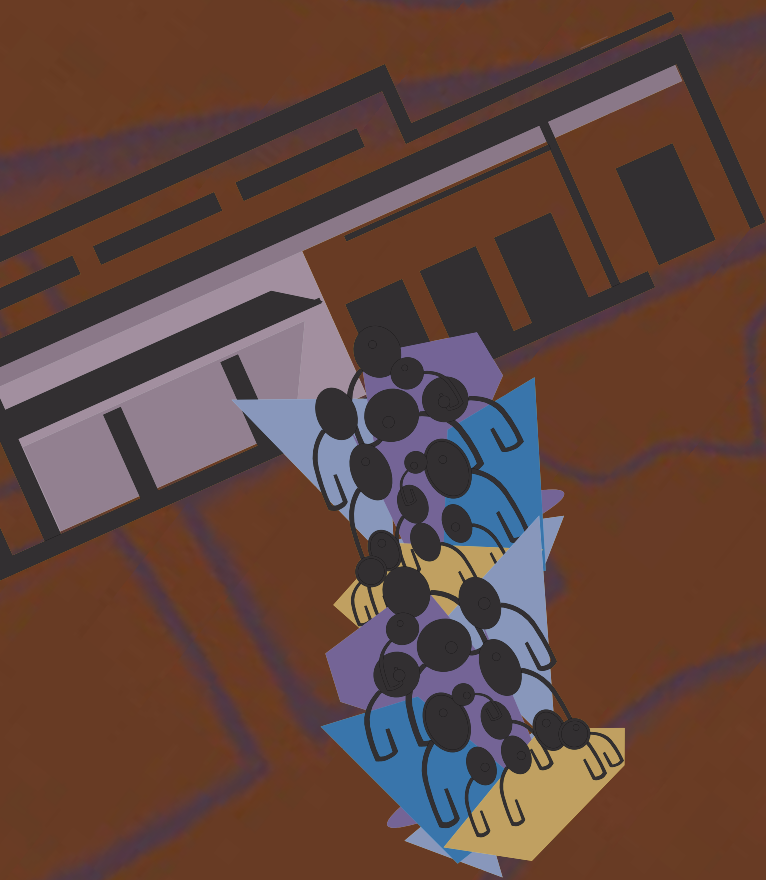


Gender analysis of health care access and utilization in Pakistan

Report on a stakeholders' workshop
Bhurban, Pakistan
28-30 August 2006



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

Appropriate access to health care and the use of health care services are crucial factors in determining positive health outcomes. Consistent research results outline the following factors contributing to health seeking behaviour: socioeconomic status (i.e. household poverty and levels of education); proximity to health facilities; type, duration and perceived severity of illness and long waiting times; inadequate or negative staff attitudes; adequate health education; and sex and gender. Restrictions on the physical mobility of women (“gate-keeping”) and restrictions on women’s decision-making, mobility and autonomy interact with the above factors to increase obstacles for women’s ability to access and use existing health care services effectively. Differences in health-seeking behaviour between men and women generally reflect that men delay seeking health care for longer but use trained allopathic services directly while women tend to practise “self-care” or use traditional medicine before seeking trained allopathic care. For certain conditions, it has been shown that women seek more health services than men, though these services are often of poorer quality and at lesser expense than trained allopathic care. Geographic location, severity of illness and higher socioeconomic status were found to influence men’s health-seeking behaviour while lower user fees, shorter duration of illness and fear of social isolation were associated with women’s health-seeking behaviour. The social determinants of health that underpin these different patterns of health-seeking behaviour, as well as how these determinants affect health equity differ from one setting to another.

The World Health Organization, in collaboration with the Institute of Public Health, Lahore, Pakistan, completed a gender assessment of health care seeking behaviour in Kasur district, Punjab, Pakistan. The study design was developed in order to better understand the interaction with gender and other social determinants of health in relation to health-seeking behaviour, access to and use of health services in the Eastern Mediterranean Region. The initial analysis of the data collected was used as a framework for a stakeholder’s workshop on gender analysis of health care access and utilization, held in Bhurban, Pakistan on 28–30 August 2006, with the objective of promoting gender mainstreaming in health policies and programmes.

The workshop was inaugurated by Dr Khalif Bile Mohamud, WHO Representative Pakistan, and by Maj. Gen (Retd) Shahida Malik, Director General Health. Dr Bile delivered the opening remarks on behalf of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his remarks, Dr Gezairy welcomed the representatives of development partners, including the Canadian International Development Agency (CIDA), the Danish Red Crescent, UNICEF and UNFPA, and acknowledged with gratitude the financial contribution of CIDA.

He noted that the WHO Regional Office for the Eastern Mediterranean had remained strong in its efforts to promote health for all through primary health care since the Alma-Ata Declaration over 25 years ago and that addressing the social determinants of health through multisectoral approaches was an integral part of the primary health care approach. Gender was acknowledged as an important social determinant of health: morbidity patterns, exposure to risk factors, and access to and utilization of health care services were

examples of areas in which differences existed among males and females and influenced health outcomes. Integrating gender considerations into health sector actions was good public health practice, and the health sector actors must be able to identify, and work to alleviate, health inequities that arose from gender roles and norms.

WHO sought to support Member States in raising awareness of gender in health issues and to find constructive ways to work in partnership to overcome the obstacles that prevented the attainment of optimal health for all. Dr Gezairy concluded by urging the participants to formulate relevant and practical recommendations to shape and optimize the development of a multi-level plan of action for the integration of gender into health policies and programmes at all levels in Pakistan.

Maj.Gen.(Retd.) Shahida Malik, HI (M), Director-General Health noted that social determinants of health care seeking behaviour and health often lay outside of the immediate realm of the health sector and yet were integral to achievement of health equity goals. The Government of Pakistan was strongly committed to the principles of the Alma-Ata Declaration and to achieving the Millennium Development Goals and Health for All and had worked closely with WHO towards achievement of these goals. Addressing gender in health was an integral component of this work, and the Government of Pakistan had taken notable steps to gender mainstreaming in the health sector.

Despite the many achievements, however, more was still needed, especially in integrating gender into planning processes and optimizing health care delivery for both men and women. The workshop was especially important in addressing this issue because it reflected evidence of gender variables in access and utilization of health care and would provide a vehicle for action for health planners and other key community and district stakeholders. She emphasized the importance of intersectoral approaches to address the long term needs of gender mainstreaming that necessarily entailed more than health service delivery, and stated that the increased capacity and a solid base of information regarding community needs would help shape appropriate health plans and interventions. She closed by expressing the hope that the workshop would produce a concrete and feasible plan of action of how to incorporate gender-based analysis in health and the integration of gender considerations in health planning.

Dr Muhammad Shafiquddin, Dr Ashfaq Ahmed and Dr Athar Saeed Dil acted as chairs throughout various sessions of the 3-day workshop. The meeting agenda, programme and list of participants are included as Annexes 1, 2 and 3 respectively. The proposed national plan of action on gender mainstreaming in health for 2006–2011 is attached as Annex 4.

2. Introduction to the WHO project on gender analysis in health care access and utilization

Ms Joanna Vogel, WHO EMRO

Appropriate access to health care and the use of these services are crucial factors in determining positive health outcomes and consistent research results outline influences of health seeking behaviour such as socio-economic status, proximity to health facilities, perceived severity of illness, staff attitudes, as well as gender. Issues in gender and health seeking behaviour can be found in restrictions on physical mobility, limited decision-making power, access to resources and degrees of autonomy. In the majority of cases these gender norms reflect a disadvantage in women's health outcomes; however, negative gender issues for men can also be found, such as greater delays for men in seeking health care than women. In order to better understand the interaction with gender and health in relation to health care seeking behaviour, access to and use of health services in the Eastern Mediterranean Region, WHO developed a project on gender analysis of health care access and utilization with an end goal to increase capacity for gender responsive planning in order to facilitate positive health outcomes.

Pakistan's commitment to gender mainstreaming seen through initiatives such as the Reproductive Health Service Package and the listing of gender as one of the priorities of the National Health Policy of 2001 provides an environment conducive for engaging heightened gender activities. Despite achievements, challenges in gender are still faced in Pakistan. The combination of facilitating environment and existing challenges provide a solid groundwork for initiating the project in Pakistan.

The project's short-term (2005–2006) goal is to build evidence through a situation analysis of how gender impacts health care seeking behaviour in Pakistan. The long-term goal (2006–2008) is to mainstream gender in health planning to reduce gender-based inequities in health outcomes. The objectives of the projects are as follows:

- Assess status of country-wide work on gender and health at macro-, meso- and micro levels;
- Perform a situation analysis on the gender variables existent in health care seeking behaviour at the district level in Kasur, Pakistan;
- Engage stakeholders in primary health care delivery in Pakistan to promote gender-based analysis and gender-responsive health planning;
- Promote capacity building for gender responsive health care provision among health care providers in Pakistan.

Gender-based analysis was used to evaluate the data gathered in Kasur district. Gender-based analysis can be used to inform all aspects of the health care system and improves the understanding of male and female differential, as well as common, needs in health.



In addition, gender-based analysis ensures that gender norms and roles are reflected in institutions, as well as at community level.

A documentary analysis that included interviews with key stakeholders in health was completed in 2005. This desk review was carried out according to existing WHO protocol on country profiles. The gender profile will be used to provide a comprehensive description of the situation of gender and health, and an inventory of gender in health initiatives existing in Pakistan, both by national and international organizations. This publication is undergoing draft revisions and will be disseminated through the WHO office in Pakistan as a means to further strengthening and developing gender-responsive health-related initiatives.

The assessment tools were developed in collaboration with WHO, national consultants, and the Institute of Public Health (IPH), Lahore in order to meet the short term goal of the project. A total of 13 tools were developed for the collection of both quantitative and qualitative data, including 2 facility-based tools for interviews with health care providers and health care users; 3 focus group guides for discussions with Lady Health Workers (LHW), health care seekers and non-health care seekers; and 8 in depth interview guides for selected stakeholders in health including policy makers at the federal levels and traditional healers.

Tools were elaborated in English and translated into Urdu, including a process of back translation. Back-translation ensured the cultural congruence of tools and data, allowing for semantic and conceptual equivalence. This is especially important when dealing with sociological terms that differ across cultures, as well as qualitative assessments that require approaches sensitive to local communication patterns in order for participants to understand what is asked of them, while ensuring the objectives of the assessment remain intact. It was anticipated that some participants may wish to express themselves in Punjabi. Given the oral-only nature of this language, and the similarities with Urdu, a Punjabi glossary for key terms was developed as additional guidance for field workers. The tools were piloted in December 2005 and revised accordingly. Issues for revision included shortening the time necessary to complete the facility based questionnaires for health care users and re-wording of questions whose meanings were misperceived by the pilot respondents.

Kasur district of Punjab was selected as the site for the situation analysis in coordination with the Ministry of Health, WHO and the Institute of Public Health. The total population of Kasur (1998 census) is 2.8 million. The rural literacy rate for women is 18.1% and for men, 44.7%. Urban literacy rate is 40.6% for women and 57.2% for men. District and *tehsil* headquarter hospitals provide secondary care and the rural health centres and basic health units (BHU) provide primary level care. Eight rural health care centres and their surrounding catchment areas provided the target population for the situation analysis. The situation assessment completed in Kasur district will not be used to generalize conditions over other areas of

Pakistan; however because gender is a social construct, it may be inferred that similar social constraints impact populations in other districts of Pakistan.

The health facility based questionnaires conducted at 8 rural health centres targeted both health care users and health care providers and separate tools were developed for each. A total of 268 health care users were interviewed at the 8 facilities, including 135 male and 133 female. The health care provider respondents included the attending medical officers at each of the rural health centres. Rural health centres have limited capacities and as such have a variable presence of health care workers in the form of male and female medical officers, dispensers, paramedics, and lady health visitors. A balance of available male and female health care workers present in the rural health care facilities was engaged in the situation assessment tools.

The focus group discussions centred on gender factors influencing access and utilization of health care and targeted lady health workers, as well as health care users and non health care users from the catchments areas of the 8 rural health centres. Non health care users were defined as those not using the centres. The approximate number of total participants for the focus group discussions was 360 male and females. The focus group participants were divided among sex to promote comfort in interaction. Likewise the sex of the interviewers was matched to the sex of the respondents in order to respect social norms. The focus group discussions with the LHW were conducted at the rural health centre level. The other focus group discussions were conducted at the village level with women and men who primarily seek formal health care services as well as those who primarily seek informal health care services. Focus group participants of the various health care seeking behaviours were selected with the assistance of LHW who are in close interaction with their community members and aware of their health seeking patterns. Criteria for focus group participants specifically depended on sex, age, and health care seeking behaviour.

In-depth Individual Interviews were conducted with stakeholders in health and health-related decision-makers from the federal to the community levels in Pakistan. The interviews focused on issues, challenges and recommendations for improved health seeking behaviour of women and men in Pakistan.

An informed consent form for participation in interviews and/or focus groups was developed in English by IPH. Based on the experience of IPH in working in Punjab province, as well as varying levels of literacy among participants, informed consent was taken orally and reflected on forms by the interviewer or someone accompanying the participant. The approximate time to complete the questionnaire for health care seekers was half an hour to forty five minutes. A private area was established within the rural health centre for the respondents and interviewer to complete the questionnaire.



Data collected from facility-based surveys were analysed using *SPSS*, and thematic and content analysis was conducted on data collected from in-depth interviews and focus-group discussions. These responses were organized under three principal questions, or stages, that can help us to understand the stages involved in health care seeking by women and men in Kasur district of Punjab. These stages reveal gender roles, norms and differences that have important bearings on health outcomes as well and help to form the basis for gender-responsive follow up actions. Stage 1 of the continuum of health seeking behaviour is how women and men decide whether to seek health care or not. Stage 2 covers the factors that are involved once men and women decide to seek health care. Stage 3 reflects the experiences of women and men once they actually seek care. The stages form a feedback loop and the experiences and perceptions that occur in one stage spill over into the influencing variables of the other stages. While a wealth of data was gathered, the analysis thus far has focused only on the influences of gender on the stages of health care access and utilization, essentially addressing the questions that prompted the project.

A few preliminary limitations have been identified. First, socio-demographic information was not always available from the qualitative tools and therefore associations with criteria such as age, marital status, level of education, source of income, type of household and other measures of socio-economic status cannot be conclusively drawn from that data. Second, health care providers' perspective is not as robust as those of health care seekers and non seekers. The voice of health care workers at the facility level were sought through facility based interviews, with a more closed ended questionnaire. Traditional healers, LHW, Lady Health Supervisors and health decision-makers were interviewed individually or in focus group discussion which allowed for more understanding of their perceptions and challenges. Medical officers (male and female), however, did not have this opportunity. One focus group with medical officers was conducted after completion of data collection to address this gap identified during preliminary analysis and community debriefings. Third, administrative delays that changed the anticipated timeline of data collection may have negatively impacted the availability and participation of respondents due to external influences of hot weather and harvesting time. In addition, it is difficult to reach some vulnerable groups of women due to specific customs. Finally, positive reporting by respondents is often a challenge for data collectors and therefore the interviewers were trained to address this possibility and access deeper into social issues. This was also addressed in tool development through triangulation. A degree of selective reporting may nonetheless be reflected in the participant responses.

3. Selected findings of the assessment of gender dimensions of health care access and utilization completed in Kasur district, Punjab 2006

Dr Shaheena Manzoor, IPH

Findings were presented along the stages of health care seeking behaviour identified in the introductory presentation.

1) Stage One: How do women and men decide to seek health care?

Perceptions of health influence when and how men and women decide to seek health care. There are many similarities in the ways in which women and men perceive the health of both sexes in facility-based surveys. While the ranking may be slightly different, a healthy man is defined by women and men as being energetic, a hard worker and happy. A healthy woman is defined in a similar way, though the emphasis is placed differently. Men rank being a hard worker as the most important characteristic for both women and men. Women agree that a healthy man is recognized by being a hard worker, but that a healthy woman is first recognized by being happy; being a hard worker falls to the third rank for women's perception of a healthy woman.

Both health care seekers and health care providers affirm that decision-making responsibility lies with men within households. Women tend to seek care for dependent children, and take advantage of the opportunity to ask questions related to their own health. Practices of son preference are present with respect to health-related decision-making. Age also seems to play a role in decision making as it would appear that decisions related to women of reproductive age are more bound by socio-cultural and gender norms of sex-matching and taboo issues. On the other hand, children and elderly appear to be free to consult any health care worker.

It would appear that members of the community prefer to seek care from those health care workers that are "known" to them. For this reason, services of traditional healers were sought and medical officers were often regarded as outsiders, foreign to local customs and cultures. Surprisingly, sex of the health care worker seemed to be an important decision-making factor only when it was related to formal health care. While the availability of female staff was cited by both women and men as an important characteristic of a good health facility in focus group discussions, facility-based interviews reported that women and men are comfortable seeking care from either a male or female health care provider. This differed, though, depending on the nature of the health problem, and for whom health care was sought.

Focus group participants seem to rank "availability of female staff" as second and third (of 11) in terms of important characteristics of a good health facility. Among these respondents, female seekers seem to place more importance than male seekers on the availability of female staff while both male and female non seekers seem to find this equally



important. The fact that male non seekers equally find the availability of female staff to be an important characteristic may impact upon decisions made with respect to the health seeking opportunities of female members of their household.

The decision to seek care, and from whom, may depend on the nature of the health problem. Many participants report that they seek care regarding sexual health matters from traditional healers. While formal health care providers report that they perceive having the capacity to address such issues, they actually report that they do not do so. It can be assumed that other taboo issues (or sensitive issues) may also be referred to traditional healers where there is a higher degree of trust and comfort.

Men and women seem to have similar knowledge of availability of health services in their catchment area. Awareness of community-based health care workers (LHW, traditional healers) seemed to be higher for both women and men than for facility-based health care workers.

Hours of operation also seem to play a role in the decision to seek care. Almost all participants (male and female) expressed a desire for 24 hour service. Some referred to their preference for LHW and traditional healers as related to their increased availability at preferable time of the day (compared to health care facilities). Other participants referred to men's opportunities to seek care from health care facilities due to conflicts between working schedules and operating hours of facilities, resulting in high opportunity costs. The cost of health services is overwhelmingly reported as too high – whether for services itself or for medicines (and presumably other forms of treatment or even diagnosis using such as X-rays, blood tests, etc.). While both men and women among health seekers, in addition to health care workers, identify cost as a decision-making factor in where to seek care it is important to note that men and women express this differently. Men seem to refer to the overall expenses of health care and transportation to facilities as being unaffordable while women seem to refer to their own individual ability to access household resources to be able to actually pay for health care services. This relates to the gendered division of decision making and resource allocation within the household wherein women are dependent on men.

2) Stage Two: Once men and women decide to seek health care, what factors are important to consider?

Indirect costs that affect access to health services include distance to health care facilities and transportation costs. Compounded by distance for all participants, is the cost associated with travel. While most women and men could reach the nearest health care facility within 30 minutes of walking distance, the costs of transportation are noted as a factor of access. This, most likely, has more direct implications for cases of referrals or emergency situations, where walking becomes a less viable option. Women must be accompanied by someone to visit a health care facility regardless of the sex of the health care worker according to custom

and household practices that limit the mobility and autonomy of women of reproductive ages. Facility-based surveys confirm that 32.3% of women reported that they did not seek care for a health problem as there was no permission from the household.

3) Stage Three: What are the experiences of women and men once they actually seek care?

To set the context of what illnesses prompted consultation, the pattern of presenting illness was investigated. Men sought care more for digestive problems than women. Women sought care especially for heavy bleeding (gynaecological) and nausea or dizziness. Both men and women equally presented to rural health centres for minor ailments, such as skin, eye, and ear ailments. More women than men presented to rural health centres for perceived emergencies, while more men than women presented for chronic illnesses.

Patients must trust their health care providers both to disclose their medical conditions and to adhere to the prescribed treatment by the health care provider. Data from respondents showed both a lack of trust in the formal health care providers and a lack of trust in the treatment prescribed. People in general were apprehensive about government provided health services and felt that the poor were not usually treated well. This lack of trust in the formal health care providers is further aggravated by the fact that the health care providers do not come from the communities of the patients and are rotated out after a few years. Respondents felt that the formal health care providers spoke in a more difficult language and communicated foreign concepts. These communication barriers discourage people from utilizing formal health care services and create social distance. Another factor that seemed to contribute to the lack of trust, especially for male respondents, was a lack of perceived good conduct by the health care providers. Short consultation times seem to further aggravate communication barriers between formal health care providers and their patients. Male respondents expressed that doctors did not give enough time to them and did not listen carefully to their health-related complaints.

Medical officers described key challenges that they and their families face in being viewed as outsiders even to extremes of being concerned with their security. Being part of an unknown environment also caused integration issues for medical officers as they perceived a lack of adequate recreational and educational facilities for their children and expressed concern for the socialization of their children. Medical officers also expressed challenges of excessive workloads exacerbated by lack of appreciation by their employers or the clients they serve. Another pressure medical officers face relate to the amount of time spent attending to medico-legal issues which necessitated their absence from duty posts while having to testify in court cases. Medical officers indicated that they were underpaid, overworked and not appreciated. Such sentiments invariably contribute to an overall demotivation and may be partially responsible for client perceptions of poor quality of care, lack of interest and poor attitude on the part of the medical officers. In addition, medical officers indicated concern about their career prospects as they were largely cut off from



facilities for continuing education which they perceived as being available in secondary and tertiary institutions, and feel this leads to stagnation.

There appears to be more trust developed with traditional healers as they usually come from local areas and are involved in their health care occupations for generations, as well as similar socio-economic standing with patients. Traditional health care providers spoke the same dialects and concepts as those of the patients which facilitated good communication between them and their patients.

Health care seeker respondents felt that medicines provided by the public sector outlets were not effective and that people needed to buy treatment from private sources of healthcare. Respondents further perceived that they were always given the same medication irrespective of the varied nature of their illness on different visits to the health facility. 75.4% of respondents that adequate availability of medicine was the most important characteristic of a health care facility. Only 43.1% of males and 33.6% of females felt adequate medicines were available at health care centres. Female respondents specifically referred to lack of X-ray or ultrasound machines in rural health facilities as well as laboratory facilities. 56.2 % of males and 35.9 % of female respondents indicated a desire for a laboratory on site. Female respondents indicated that lack of equipment at health care facilities influenced them to turn to more traditional forms of medicine where equipment was not necessary for healing. One range of service gap indicated by the data, especially for men, was a lack of sexual health services at government health facilities. 41.5% as opposed to 25% women sought expanded health services from government health care facilities. Both male and female respondents said that they needed to go to the General Hospital (a teaching hospital at Lahore) for cardiac, dermatological, gynaecological, diabetic and hypertension complaints.

Other factors influencing health care access and utilization for males and females centred on operational factors at the health care facilities. For example, hours of service seemed to be particularly important for men. 30% of men as opposed to 10.9% of women felt that the operating hours were not convenient. The need for sex segregated waiting areas was also expressed as an important variable at the health care facility. This was more important for men than for women however, with 26.5% of men, as opposed to 12.5% of women, indicating it as an influencing factor.

While women and men indicated they were equally comfortable in receiving care from a provider of the opposite sex (67.7 % and 66.7%), triangulation indicated a contradiction in that 57% of men also said that presence of a male health care provider was an important aspect of a quality health care centre, as opposed to 15.8% of women. Males preferred for women to consult with same sex providers. For confidential issues, it was less comfortable for women (73.7%) to seek care from male doctors than for men to seek care from female doctors (46.7%).

4. Group work

4.1 Session 1: Gaps of the study findings discussed and priority issues in gender in health in Pakistan identified

Participants were divided into three groups with the purpose of discussing the gaps of the study findings and outlining priority issues in gender and health care seeking behaviour in Pakistan. The groups then prioritized the issues, keeping in mind urgency, feasibility, and affordability.

Group 1 priority issues

- At intrapersonal and at society level: lack of awareness at personal level about diseases/ health, beliefs and norms affect the health seeking behaviours and perceptions (long term, 6+ yrs)
- Costs and poverty, distance to facilities (medium term, 4–5 yrs)
- Lack of health facilities utilization due to the absence of female staff at rural health centres (medium term, 4–5 yrs)
- Lack of trust and confidence of communities towards health care providers (long term, 6+ yrs)
- Lack of mobility and autonomy for women (long term, 6+ yrs)
- Lack of medicines in rural health centres (short term, 0–3 yrs)
- Behaviour of health personnel (long term, 6+ yrs)

Group 2 priority issues

- Women's perception of health and reproductive health (they feel happy) – a barrier to health access (short–medium term, 0–5 yrs)
- Socioeconomic status of women affects their access to health care (medium term, 4–5 yrs)
- The vulnerable groups in the community including widows, divorced women, elderly, adolescents and disabled persons are disadvantaged and face barriers in seeking care for rural health problems (short–medium term, 0–5 yrs)
- The study did not look at referral system of emergency cases (short–long term, 0–6+ yrs)
- The timing of health services is inconvenient for men. There is a policy gap which needs to be addressed (short–long term, 0–6+ yrs)

Group 3 priority issues

- Gender biases (long term, 6+ yrs)
- Poor communication skills (short term, 0–3 yrs)
- Gender insensitive planning of health programme (short term, 0–3 yrs)
- Awareness about personal susceptibility seriousness, danger sign and way out (medium term, 4–5 yrs)
- KAP (knowledge, attitudes, practices) study of traditional providers and seekers (short term, 0–3 yrs).

4.2 Session 2: Mapping of possible actions directed at addressing gender dimensions and responsible actors

The second working group sessions focused on the mapping of possible actions arising from the priorities outlined during the first working group sessions and included assignment of responsible actors, level of operation and monitoring indicators. The priorities from all sessions were subsequently organized under seven strategic priorities and consolidated into a multi-level plan of action (Annex 4). The group agreed that due to the urgency of immediate action, it would be more constructive to consolidate recommended activities into a five-year plan.

5. Concluding session

5.1 Multi-level plan of action

Dr Muhammad Shafiquddin, Chief Health, Ministry of Planning and Development, introduced the presentation of the multi-level plan of action, describing the consensus by which it was formed and the hard work the participants put into its development. He endorsed the sound concepts behind the strategic plan and emphasized its relevance and importance in facilitating equitable health outcomes.

The multi-level plan of action was presented by the Rapporteurs from each of the working groups and following some amendments, was endorsed by the participants and the chair of the session, Dr Athar Saeed Dil, Chief Health, Federal Ministry of Health.

5.2 Ways forward

Dr Khalif Bile Mohamud, WHO Representative, Pakistan

Dr Bile began by stating that while the workshop culminated activities of 2005 and 2006, it was actually a starting point for meeting the long term objectives of the project which is gender mainstreaming of health care planning as a means to promote health equity. He noted it was clear that the participants had worked hard over the past few days to develop such a comprehensive plan of action on gender mainstreaming in health and that the participants should be proud of the output of the workshop. Dr Bile cautioned however that now is when the real work begins, the advocacy of the action plan to all concerned stakeholders, and the implementation of the plan. He stated that it was up to the participants to ensure that this is not yet another document that ends up gathering dust on a shelf and that the participants must take ownership of the action plan and to take this work forward.

6. Roundtable session

Following the closing session of the workshop, a roundtable was convened between development partners and the Federal Ministry of Health, Pakistan, to discuss the ways forward and to identify synergies between the multi-level plan of action and the respective programmes of the participating agencies/departments.

The establishment of technical task force on gender and health was suggested using the plan of action as its starting point for action. The need for commitment by the Ministry of Health to the task force was emphasized, and the Ministry of Health offered its support. It was established that endorsement of the plan of action by Secretary Health was the necessary next step and nomination of Dr Ahmed as focal point gender in health was suggested. Other follow up actions suggested was a mapping by development partners of responsibilities, programmes/activities, and commitments that have synergy with the plan of action. In addition the development of a health and gender technical paper for Pakistan using the gender profile as starting point was discussed. The initiation of gender based analysis of existing health data and spearheaded by the gender in health technical task force was put forward as one of the terms of reference of the task force. There was also an expressed need for concentration by the task force on the nursing profession and the need to raise awareness of critical function of nursing profession. The engagement of parliamentarians in addressing multisectoral aspects of the plan of action was identified as critical. It was decided that the plan of action and the creation of the health and gender technical task force would be introduced as an agenda item during the donor meeting being hosted by WHO Pakistan on 4 September 2006. Finally, wide dissemination of the plan of action and the health and gender technical task force to other stakeholders in health in Pakistan was deemed an important next step.

Annex 1

Agenda

1. Registration
2. Opening session
3. Regional Director's message
4. Inaugural address to the Ministry of Health
5. Introduction to gender assessment
6. Preliminary findings of gender assessment
7. Working session 1: Discussion of gaps in study findings/issues that have not emerged from the study but need to be addressed
8. Working session 2: Prioritization of all issues
9. Working session 3: Mapping of possible actions and responsible actors
10. Working session 4: Development of multi-level plan of action
11. Presentation of Consolidated Action Plan
12. Roundtable with development partners and the Ministry of Health
13. Closing session

Annex 2

Programme

Monday 28 August 2006

- 8:30–9:00 Registration
- 9:00–9:45 Plenary Session 1: Opening remarks, keynote address, and inaugural address by the WHO Representative in Pakistan and Ministry of Health officials
- 9:45–10:15 Plenary Session 2: (1) Introduction of participants; (2) Election of Chairperson and Rapporteur; (3) Adoption of the Agenda; (4) Objectives, mechanics and expected outcomes of the workshop
- 10:15–11:00 Plenary Session 3: Introduction to the WHO project on gender analysis in health care access and utilization
- 11:00–11:30 Plenary Session 4: Presentation on selected findings of the assessment of gender dimensions of health care access and utilization completed in Kasur District, Punjab 2006
- 11:30–1:45 Plenary
- 1:45–3:30 Working group Session 1: Discussion of gaps in study findings/issues that have not emerged from the study but need to be addressed
- 3:30–5:00 Plenary Session 5: Presentation of working groups

Tuesday 29 August 2006

- 9:00–11:00 Working group Session 2: Mapping of possible actions directed at addressing gender dimensions and responsible actors (federal, provincial, district community)
- 11:00–11:30 Plenary Session 6: Presentation by working group
- 11:30–2:30 Working group Session 3: Development of multi-level plan of action building on identified actions
- 2:30–4:30 Plenary Session 7: Presentation by working groups and discussions

Wednesday 30 August 2006

- 9:00–11:15 Plenary Session 8: Presentation of multi-level action plan
- 11:15–11:45 Plenary Session 9: Major Conclusions and Future Directions
- 11:45–1:30 Plenary Session 10: Closing session
- 1:30–3:30 Roundtable of development partners and Ministry officials

Annex 3

List of participants

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Mr Muhammad Sajjad Shafiq, Senior Secretary, WHO Pakistan
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Annex 4

Proposed plan of action on gender mainstreaming in health, 2006–2011

This proposed plan of action on gender mainstreaming in health is the outcome of deliberations by multiple stakeholders at a WHO sponsored workshop on gender analysis, health care access and utilization in Pakistan that deliberated on the results of a recent assessment carried out in Kasur district, Punjab on gender differences in health-seeking behaviour, access and use of health care services. Working groups at the workshop identified priority gender and health issues, recommended actions, responsible actors and related indicators of success. After much debate and discussion, consensus emerged on the following seven strategic issue areas towards the progressive and effective mainstreaming of gender issues in health sector activities in Pakistan.

The proposed plan of action sets out a five-year road map for scaling up health-related actions that will promote women's empowerment and gender equality. Specifically, this proposed plan of action aims to improve health outcomes for women and men, boys and girls in Pakistan by addressing gender norms that may impede their full realization of good health through adequate access to appropriate and affordable quality health care services. Short term activities are proposed over a two year period, while a three to five year time frame is suggested for medium term activities. It is expected that a review will be conducted after two years and an overall evaluation of the implementation of this plan of action conducted at the close of the five-year period. At this time, new discussions will need to be held to revisit the strategic issue areas and the need for continuing or new activities. All strategic issue areas are formulated to respond to equitable access and use of health care services for women and men, boys and girls in Pakistan. Action in one area impacts successful outcomes of all others with three important cross-cutting themes:

- Gender equality;
- Community participation;
- Civil society involvement at all levels.

This proposed plan of action will require technical, financial and political support and commitment from multiple stakeholders in order to yield the expected results of improved conditions of gender equality and improved health outcomes for women and men, boys and girls in Pakistan. While new activities may be required in the strategic issue areas, the activities listed in this plan of action provide a crucial starting point to address the most urgent gender inequalities in health. It is the hope of the working groups Pakistan that this proposed plan of action yield sustainable, long term results.

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
1. Lack of gender-sensitive health policies and programme planning	Gender inequality and improved women's health outcomes require high level political and financial commitments from all levels of government and partners through institutional policies and programmes that consider and address the differential health needs of women and men.	1.1. Conduct advocacy for gender-sensitive planning and gender-responsive budgeting in health programmes	Short term (0–2 yrs)	1.1.1 Increased budget envelope for gender-sensitive health programmes 1.1.2 Number of gender and health capacity building workshops or events held for policy- and decision-makers 1.1.3 Number of advocacy events held (i.e. seminars, conferences, walks, advocacy kits)	Ministry of Health Other related sectors of government NGOs Civil society International agencies Donors Multisectoral partners
		1.2. Carry out evidence-based planning for gender and health issues	Short–medium Term (0–5 yrs)	1.2.1 Number of policies and programmes developed or revised informed by gender and health research and activities and sex disaggregated health data	
		1.3. Involve civil society organizations, especially women's groups, in planning and programme processes (phases of assessment, planning, implementation, evaluation)	Short–medium Term (0–5 yrs)	1.3.1 Number of civil society representatives consulted for policy and programme planning issues 1.3.2 Number of workshops, meetings or consultations with civil society organizations on health policies and programme planning processes	

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
		1.4. Develop and strengthen mechanisms to ensure sustainability of gender mainstreaming in health policies and programme planning (i.e. via gender working groups, gender focal points in Ministry of Health and Health Departments, INGAD, health sector donor groups, Pakistan Health Policy Forum, etc.)	Short term (0–2 yrs)	1.4.1 Number of operational mechanisms established to address gender mainstreaming in health	
		1.5. Strengthen multisectoral collaboration	Short term (0–2 yrs)	1.5.1 Number of joint initiatives among different sectors and levels of government on gender and health policies and programme planning	

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
2. Inadequate women's social and economic empowerment	Certain cultural barriers result in limited decision-making powers, restricted mobility, and lack of access to social, economic and political resources for women which negatively impact on health outcomes. In order for women and girls to realize their full health potential, empowerment strategies are necessary to overcome these cultural barriers.	2.1. Conduct advocacy for women's empowerment in collaboration with other sectors and partners based on linkages with health outcomes	Short-medium term (0-5 yrs)	2.1.1 Number of collaborative initiatives led by the Ministry of Health with other sectors on linkages between women's empowerment and health outcomes	Ministry of Health Other related sectors of government Religious and community leaders Health care providers NGOs Civil society International agencies Donors Multisectoral partners
		2.2. Ensure gender-sensitive health education for men and women, girls and boys	Short term (0-2 yrs)	2.2.1 Health-related curricula revision to incorporate key gender and health issues 2.2.2 Number of training workshops held with teachers, professors and other educators on key gender and health issues	
		2.3. Establish vocational training and centres for women	Short term (0-2 yrs)	2.3.1 Number of established, functional training centres for women 2.3.2 Number of female beneficiaries of vocational training activities	
		2.4. Create women-friendly spaces and women's resource centres	Short term (0-2 yrs)	2.4.1 Number of functional resource centres for women 2.4.2 Number of women's associations, clubs, meeting spaces established	
		2.5. Provide culturally appropriate micro-credit schemes for women	Short term (0-2 yrs)	2.5.1 Number of soft loans issued to women 2.5.2 Total amount of funds dispersed to women through micro-credit schemes 2.5.3 Number of audits initiated on women's microcredit loans 2.5.4 Percentage of women with increased income	

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
3. Weak health literacy	<p>Inappropriate knowledge and/or perceptions about physical and mental health-related issues at the individual, inter-personal, community and organizational levels negatively affect female and male health-seeking behaviour. In particular, inappropriate knowledge and/or perceptions about:</p> <p>a) risk factors; b) signs and symptoms; c) perceived salience (perceived susceptibility, perceived seriousness, perceived threat); d) appropriate and alternative care-seeking.</p>	3.1. Conduct evidence-based, culturally appropriate and targeted health education campaigns	Short term (0–2 yrs)	3.1.1 Number of health sessions conducted with women and men in community- and facility-based settings 3.1.2 Number of health sessions conducted with boys and girls in community-based or school settings 3.1.3 Number and type of material disseminated on gender and health issues (i.e. written, posters, radio and television spots)	Ministry of Health Other related sectors of government Religious leaders Health care providers Teachers NGOs Civil society International agencies Donors Private sector Media Multisectoral partners
		3.2. Conduct evidence-based, culturally appropriate and targeted community mobilization campaigns	Short term (0–2 yrs)	3.2.1 Number of public health education and community mobilization campaigns informed by community needs assessments 3.2.2 Number of key messages on gender and health disseminated at community level for males and females	

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
4. Insufficient access to health care services for women	Social norms may result in women and girls experiencing barriers to access health care services due to a lack of: a) availability of health care services; b) affordable health care services; c) proximal health care services.	4.1. Ensure quality health care services are available for women	Short-medium (0–5 yrs)	4.1.1 Increased number of women accessing FLCF 4.1.2 Increased satisfaction expressed by women of health care services	Ministry of Health Other sectors of government NGOs Civil society International agencies Donors
		4.2. Include women in health planning processes	Short-medium term (0–5 yrs)	4.2.1 Number of civil society representatives consulted for policy and programme planning issues 4.2.2 Number of workshops, meetings or consultations with civil society organizations on health policies and programme planning processes	
		4.3. Explore alternative health care financing mechanisms (i.e. moving from out-of-pocket to risk-pooling mechanisms) for women and other vulnerable groups	Short-medium term (0–5 yrs)	4.3.1 Number of consultations, meetings on alternative health care financing mechanisms for women and other vulnerable groups 4.3.2 Number of piloted alternate health care financing mechanisms	
		4.4. Address women's restricted mobility and permission-seeking requirements	Short-medium (0–5 yrs)	4.4.1 Number of alternate methods of transportation to health care facilities for women established 4.4.2 Number of community outreach activities directed at promoting timely health seeking behaviour for women, among men and community leaders	
	(See also activities under other Strategic Issue Areas, notably Strategic Issue Areas 1, 2 and 5.)				

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
5. Lack of appropriate health care services	The quality of health care facilities influences health seeking behaviour and, in turn, health outcomes for men and women, girls and boys. Specifically, insufficient supplies, functioning referral systems and health-related infrastructure have considerable impact on user perceptions, satisfaction and treatment adherence.	5.1. Ensure comprehensive provision of supplies, diagnostic facilities and medicines in proportion to community needs	Short-medium (0-5 yrs)	5.1.1 Number of essential needs checklists for assessing health facility capacity to respond to specific health needs of men and women, boys and girls	Ministry of Health Other sectors of government Health care providers Academic or teaching institutions Civil society International agencies Donors Private sector
		5.2. Improve health facility infrastructure	Short-medium term (0-5 yrs)	5.2.1 Number of partitions built or installed to ensure privacy during physical examinations at health facilities for women and men, boys and girls	
		5.3. Ensure a functional referral system	Short-medium (0-5 yrs)	5.2.1 Number of partitions built or installed to ensure privacy during physical examinations at health facilities for women and men, boys and girls 5.2.2 Number of health care facilities enhanced with welcoming and inspiring environments and/or atmospheres 5.2.3 Number of increased security provisions for health care providers 5.3.1 Percentage of referral cases to secondary and tertiary care for women and men out of total admissions	

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
6. Unavailable and inadequately trained health care providers	<p>Limited availability and capacity of male and female health care professionals influences health care utilization in different ways for females and males. This may be due to:</p> <p>a) lack of female staff at rural health care facilities;</p> <p>b) lack of capacity with respect to technical knowledge and communication skills;</p> <p>c) inappropriate attitudes and behaviours of health care providers towards women and men, girls and boys.</p>	6.1. Identify and recruit skilled female workforce	Short term (0–2 yrs)	6.1.1 Number of newly recruited female health care providers	Ministry of Health Other sectors of government Health care providers Public health trainers Academic or teaching institutions NGOs Civil society International agencies Donors Private sector
		6.2. Provide and create opportunities and incentives for female and male health care providers in rural health centres	Short term (0–2 yrs)	6.2.1 Number of additional opportunities and incentives created for female and male health care providers in rural health centres	
		6.3. Identify skilled staff (male and female) from within the community to address specific health needs of men and women, girls and boys	Short term (0–2 yrs)	6.3.1 Number of male and female community members trained to become auxiliary health care providers	
		6.4. Strengthen the capacity of health care providers to address gender and health issues	Short–medium Term (0–5 yrs)	6.4.1 Number of capacity building workshops for health care providers on gender and health issues	
		6.5. Develop gender-focused undergraduate and postgraduate health-related curricula	Short term (0–2 yrs)	6.5.1 Number of academic disciplines that have developed gender-focused, health-related undergraduate curricula	
		6.6. Provide in-service gender-sensitive training and orientation sessions on how gender influences health	Short term (0–2 yrs)	6.6.1 Number of health facilities conducting regular in-service gender-sensitive training workshops 6.6.2 Number of health facilities and teaching institutions addressing how gender influences health	

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
		6.7. Conduct PNA (Performance Needs Assessment) for health care providers with respect to gender differences in health to inform continuing education	Short-Medium Term (0-5 yrs)	6.7.1 Number of PNAs conducted for male and female health care providers with respect to gender differences in health	
		6.8. Strengthen collaboration between teaching institutions and field level health services	Short-medium term (0-5 yrs)	6.8.1 Number of collaborative activities implemented between teaching institutions and field level health services	
				6.8.2 Number of postgraduate opportunities offered to health care providers based in rural health care centres	
				6.8.3 Number of in-service training sessions for health care providers	

Strategic issue area	Rationale	Recommended actions	Expected timeline	Indicators of success	Responsible actors
7. Lack of gender-sensitive health research	Strengthened evidence base on gender and health issues from both user and provider perspectives is required to adequately inform policies and programme planning.	7.1. Contribute to the evidence base of gender and health issues in Pakistan through operational and participatory research for evidence-based policy making and programming	Short-medium term (0-5 yrs)	7.1.1 Increased funding allocations for gender and health research activities	Ministry of Health Academic institutions Health care providers NGOs Civil society International agencies Donors Multisectoral partners Private sector
				7.1.2 Number of gender and health research projects initiated and/or completed	
				7.1.3 Number of recommendations or interventions implemented from gender and health research activities	
		7.2. Conduct baseline assessments and analysis of existing databases of gender and health issues in order to develop adequate interventions and public health campaigns	Short-medium Term (0-5 yrs)	7.2.1 Mapping and consolidation of existing gender and health research activities completed	
				7.2.2 Number of baseline assessments conducted with health care providers and users	

