ESS Extension of Social Security

Evidence on gender inequities in social health protection: The case of women living in rural areas

Xenia Scheil-Adlung and Catharina Kuhl

ESS Paper N°29

Global Campaign on Social Security and Coverage for All

International Labour Office

Social Security Department
Geneva

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First published 2012

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ILO Cataloguing in Publication Data

Evidence on gender inequities in social health protection: the case of women living in rural areas / Xenia Scheil-Adlung, Catharina Kuhl; International Labour Office, Social Security Department. - Geneva: ILO, 2012
iii. 28 p.

ISBN: 9789221258780; 9789221258797 (pdf)

International Labour Office; Social Security Dept

medical care / access to care / scope of coverage / social protection / sex discrimination / rural women

02.07.4

ILO Cataloguing in Publication Data

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Printed in Switzerland

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1. Inequalities in health: What are the issues for rural women?

While in many developing countries, urban women have achieved some progress towards equality due to better chances in growing formal economies, rural women are often stuck in harsh living and working conditions in informal economies, e.g. as landless labourers or domestic workers. Often society, economy, institutions or gender-blind legislation oppresses equality and opportunities for rural women, including equity of access to health services. As a result, women, and particularly rural women, experience severe effects on their health, including unnecessary suffering and premature death.

Despite these inequities, over the past years, progress in improving social health protection for women and related impacts on health outcomes has been achieved, even in some of the poorest countries, as noted below:

- Since 1950, the life expectancy of women has increased significantly and today exceeds the life expectancy of men in all regions. [1]

- In addition, global maternal mortality has declined by about one third over the past decade from 1990 to 2008 and has fallen by as much as 26 per cent in sub-Saharan Africa. [2]

We find **stark inequalities in life expectancy**, however, between women living in low, middle and high-income countries ranging from around 45 years for women in Afghanistan to 87 years for women in Japan. [3] Within countries, an important rural/urban divide in life expectancy also affects women, e.g. life expectancy in some rural parts of Indonesia is ten years below the national average [4] and in rural China is over five years lower than for urban residents. [5]

Data also show that **women bear a greater burden of disease** than men – not only due to maternity – but throughout the course of their lives. Worldwide, HIV/AIDS and maternal conditions cause 19.2 and 14.6 per cent of deaths in women aged 15-44 respectively. [6] Emerging geographical disease patterns imply a greater need for health care among women living in rural areas, as:

- Maternal mortality is typically higher in rural areas than in urban areas. [7, 8]

[1] UNDESA, Demographic determinants of population ageing, Database available at http://www.un.org/esa/population/publications/worldageing19502050/pdf/ (accessed 9.5.2011)

[2] WHO, *Trends in Maternal Mortality: 1990 to 2008*, Geneva 2010.

[3] UNDP, *Human Development Indicators*, New York 2010.

[4] ADB, *The Quality of Life in Rural Asia*, Manila 2001.

[5] UNDP, The national development reports for China, New York 2010.

[6] WHO, *Women and health. Today's evidence, tomorrow's agenda*. Geneva 2009.

[7] WHO, *Maternal Mortality*. Fact Sheet No. 348. November 2010. Available from http://www.who.int/mediacentre/factsheets/fs348/en/index.html

[8] ADB, *The Quality of Life in Rural Asia*, Manila 2001.

- HIV/AIDS prevalence is higher for women than for men in both rural and urban areas of most countries (Figure 1). Prevalence is currently lower in rural areas, but despite declining in urban areas, it is on the rise in rural settings,[9] with women at a higher risk of contracting the disease.

The root causes behind these developments are diverse and are related to the socio-economic status of (rural) women, the role of women in society and in social health protection coverage, resulting in barriers of accessibility to health care.

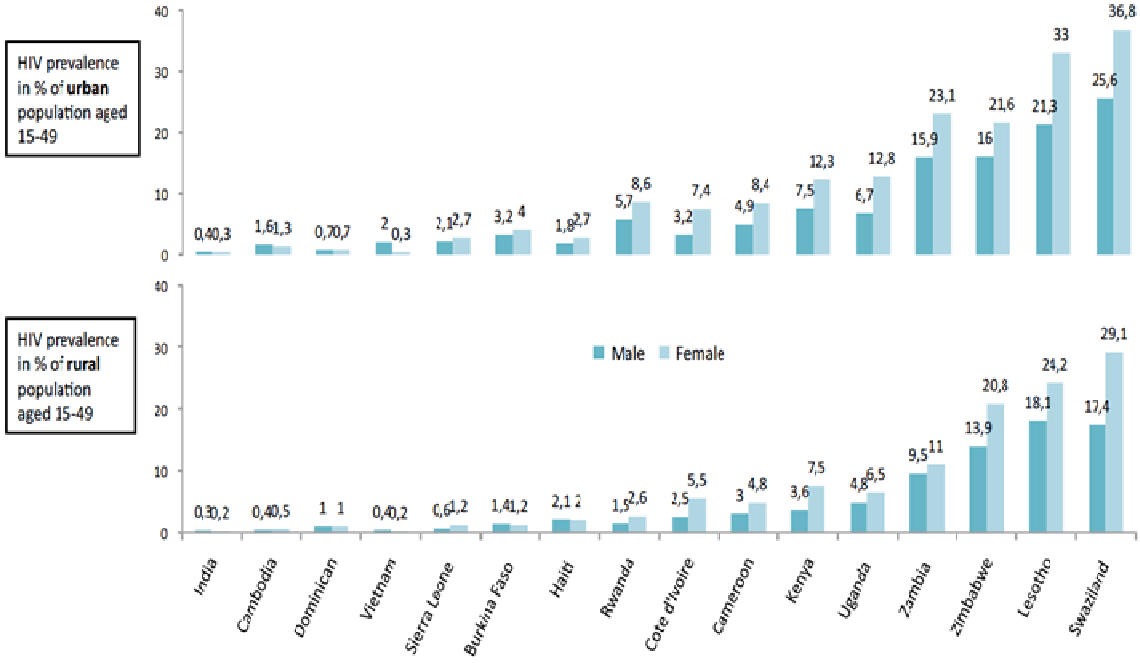
This analysis focuses on providing evidence of inequalities in social health protection experienced by rural women. Given the scarcity of available data in low-income countries, this report will focus on the following two aspects of health services in order to highlight gaps in access to health care:

- **utilization of maternal health care, including antenatal care and skilled attended births**, and

- **utilization of antiretroviral treatment**.

With strong international donor involvement in maternal health and HIV/AIDS in the context of the MDGs, utilization of other health services can be assumed to be lower.

Figure 1. HIV prevalence of the rural and male and female population aged 15-49



Source: HIV/AIDS Survey Indicator Database, http://www.measuredhs.com/hivdata, accessed 14.05.2011.

[9] UNAIDS/WHO, *AIDS epidemic update*, Geneva 2009.

2. What are the differences in utilization of health care between men and women, and women living in rural and urban areas?

2.1. Differences in utilization of health care between men and women

Linked to a higher burden of disease throughout the course of their lives, utilization of health services – excluding maternity-related care – is higher for women than for men for both in- and outpatient services.

Data on doctors' consultations [10] and inpatient hospital discharges in the European region support findings of higher utilization of health care by women. For the latter indicator, in 2005, utilization of inpatient services in the EU was highest in Austria (28.7 per cent) and lowest in Cyprus (6.3 per cent), showing wide regional disparities. [11]

Although women utilize health services more often, more women also report unmet needs for health care. [12] In low income countries, unmet needs are often linked to lower utilization. This is the case in rural Ghana, for example. Both low utilization rates and unmet needs are more common in rural areas than in urban areas, and more common for women than for men. Gaps are largest in rural coastal areas: only 50.5 per cent of women reporting an illness consulted a doctor, compared to 56.1 per cent of men. [13]

2.2. Differences in utilization of health care by women living in rural and urban areas

Globally, inpatient services are used by 55 per cent of women aged 20-59 in low income countries and by over 60 per cent in high income countries. For outpatient services however, we find a wide gap: utilization rates of the poorest women in lower income countries are 50 per cent below those of the wealthiest women in higher income countries (Figure 2). [14] There are also regional and intra-country inequalities that must be taken into account.

[10] OECD, *Health at a glance 2009. OECD Indicators*, Paris 2009.

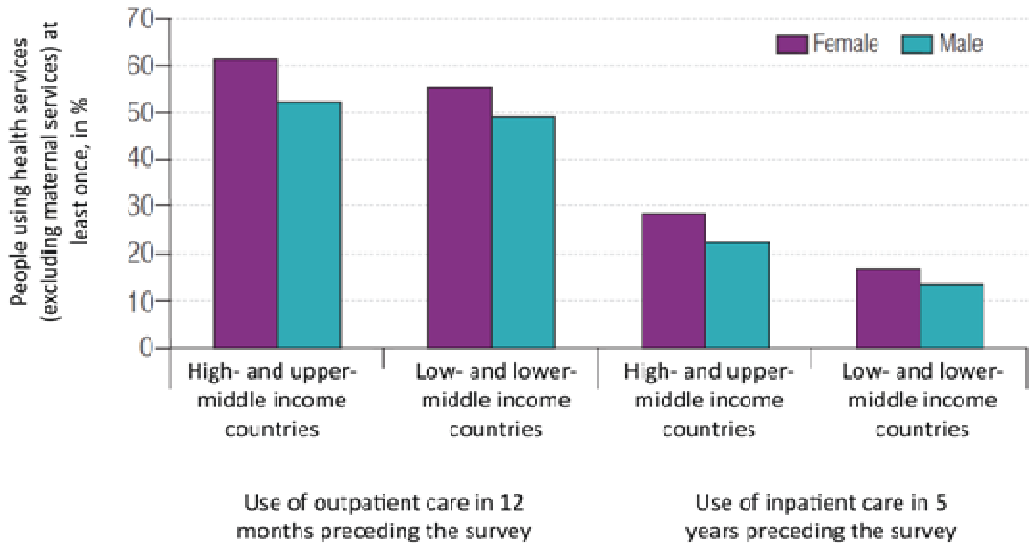
[11] Faculty of Medicine Carl Gustav Carus. Research Association Public Health Saxony and Saxony-Anhalt. Technische Universität Dresden, *Data and Information on Women's Health in the European Union*. EC, Director-General for Health & Consumers, 2009.

[12] EUROSTAT, *People with unmet needs for medical examination by sex, age, reason and income quintile* (per cent). Available at http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/EN/hlth_care_silc_esms.htm (accessed 12.05.2011).

[13] Ghana Statistical Service, *Ghana Living Standards Survey. Report of the fifth round* (GLSS 5), 2008. Available at: http://statsghana.gov.gh/docfiles/glss5_report.pdf

[14] WHO, *Today's evidence, Tomorrow's agenda*, Geneva 2009.

Figure 2. In- and outpatient utilization of the age group 20-59 by sex and country income group, 2002-2004



Source: World Health Surveys in 59 countries 2002-1004, WHO, Today's evidence, tomorrow's agenda, Geneva 2009.

At the country level, such differences might be very significant as observed in Ghana. In rural savannah areas, only 20.1 per cent of women reporting ill consulted a doctor compared to an average of 49.7 per cent in urban areas and 77.9 per cent in Accra. [15]

Furthermore, differences in rural/urban utilization of health services can be shown using the example of maternal care consisting of antenatal care and skilled health personnel. [16] Figure 3 provides an overview of utilization of antenatal care (ANC) in rural and urban areas of selected countries in the African, Asian, Latin American and European regions.

Among the selected countries in the African region, utilization rates of ANC are lowest in rural Africa:

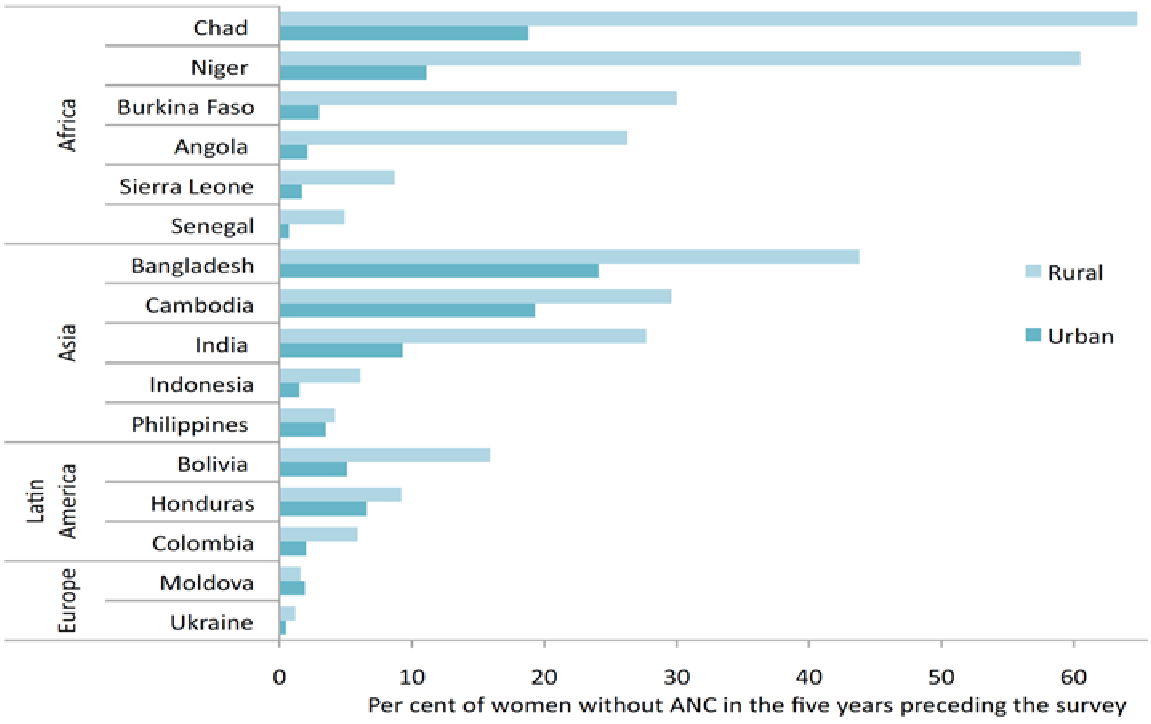
- In Angola, as many as 26.3 per cent of women in rural areas do not access antenatal care compared to only 2.1 per cent in urban areas.
- In Burkina Faso, these figures stand at 30 per cent and 3 per cent respectively.
- In Chad the figures are 64.8 per cent in rural areas and 18.8 per cent in urban areas.
- In Senegal and Sierra Leone, data indicate higher rates of utilization overall, but inequalities are more pronounced: four times as many rural women report not having accessed ANC in Sierra Leone.

[15] Salisu, A.; Prince, V. Health care in Ghana, Vienna: Austrian Red Cross and ACCORD; Ghana Statistical Service, Ghana Living Standards Survey, Report of the fifth round (GLSSS), 2008.

[16] WHO, Statistical Information System, Indicator definitions accessed on 26 September 2011 http://www.who.int/whosis/indicators/compendium/2008/3acf/en/index.html

- In Niger, 60.5 per cent of women in rural areas do not utilize antenatal care, compared to 11.1 per cent of women in urban areas.

Figure 3. Inequities in utilization of antenatal care by area of residence in selected countries of Africa, Asia, Latin America and Europe, 2010 or latest available year



Source: DHS Macro International Inc., 2011. Measure DHS STAT compiler. Accessed 27.04.2011.

Countries in Asia also show significant rural/urban differences in utilization of ANC:

- In Cambodia and Bangladesh, non-utilization of ANC by rural women is high at 29.6 and 43.8 per cent.
- In India, large inequalities in utilization of ANC are also found: three times more rural than urban women do not receive any ANC services.
- In Indonesia, the figures are much lower, but in rural areas, four times as many women report not having accessed ANC (1.5 per cent and 6.1 per cent respectively).

In the Latin American region non-utilization of ANC is also high:

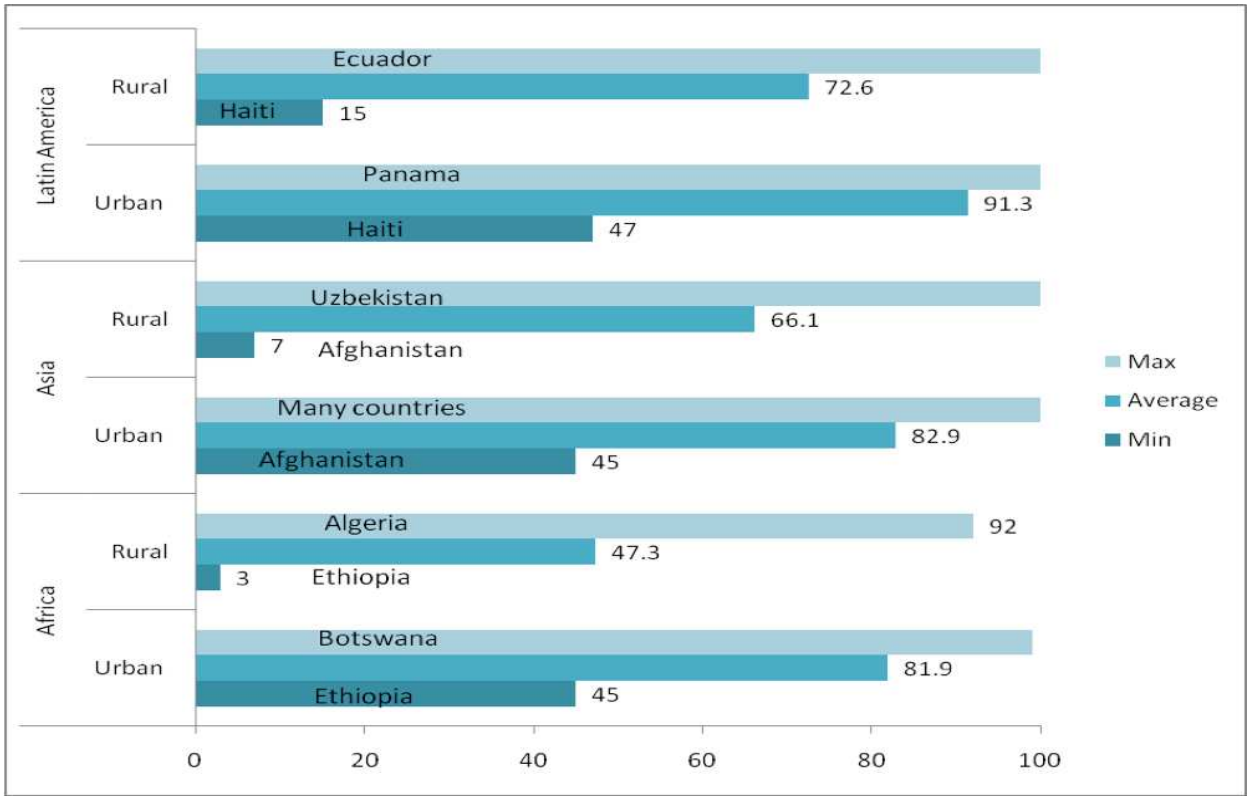
- In rural Bolivia at 15.9 per cent, compared to 5.1 per cent in urban areas; and
- In Honduras, where rural non-utilization is 9.2 per cent, compared to 6.6 per cent in urban areas.

In the European region, rural/urban differences in utilization are less significant but still evident, e.g. in the Ukraine, the figures for women in rural areas were 1.2 per cent and 0.5 per cent for women in urban areas.

Stark rural/urban differences are also found when examining different indicators such as the number of births attended by health personnel. Figure 4 presents data on the percentage of skilled attended births by rural and urban areas of the African, Asian and Latin

American regions, which confirms findings of lower average utilization rates in rural than in urban areas.

Figure 4. Rural and urban inequalities in births attended by skilled health personnel in selected countries of Africa, Asia and Latin America, 2009 or latest available year



Source: UNICEF, Data base accessible at http://www.childinfo.org/delivery_care_countrydata.php

On average, the percentage of skilled attended births of women in rural areas of Africa is the lowest at 47.3 per cent. In the Asian region, utilization amounts to 66.1 per cent on average whereas in Latin America it is 72.6 per cent; however, in all regions we find stark variations among countries.

3. What are the barriers to utilization of health services for women in rural areas?

Utilization of health services by women in rural areas is determined by various underlying factors. Besides socio-cultural accessibility, barriers to health care relate particularly to:

- financial accessibility;
- geographical accessibility; and
- availability and quality of services.

The issues of financial and geographical accessibility for rural women are closely interlinked. In terms of financial accessibility, the income earning activities of women may be limited, they may have limited decision-making roles within their households and little control over household finances. Rural women may have geographical accessibility issues that may restrict their ability to physically travel to the required health services, such as the cost of travel, the safety of the travel or the cultural acceptability of travelling women. These issues are aggravated by gaps in the availability of quality services, including the absence of female health providers, language barriers, and ethnic barriers.

3.1. Financial barriers: Can women in rural areas afford health care?

The costs of accessing health care, particularly out-of-pocket payments (OOP), can have impoverishing effects and cause catastrophic health expenditures when exceeding the household's capacity to pay. Thresholds for health expenditures are typically set at 40 per cent of household disposable income[17] or 10 per cent of total household budget.[18] The impact of OOP is more severe for those with little income and savings, such as women, and is often greater in rural areas.[19] As a result, such costs may not only push the vulnerable into deeper poverty, but can also deter those unable to pay from accessing care in the first place and thus constitute financial barriers to accessing health services.

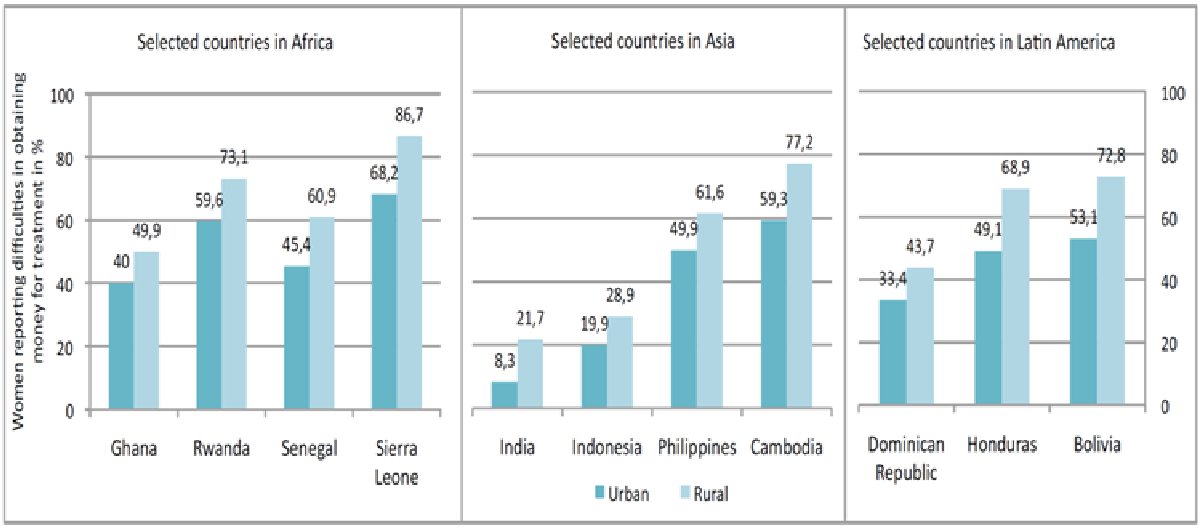
Figure 5 displays financial barriers to accessing health care reported by women in selected countries of Asia, Africa and Latin America.

[17] Xu, K. et al. "Household catastrophic expenditure: a multi-country analysis". In: *The Lancet* 2003, Vol. 362, pp.111-117.

[18] Van Doorslaer et al. "Catastrophic payments for health care in Asia". In: *Health Economics* 2007, Vol. 21, pp. 1159-1184.

[19] Saksena, P.; Xu, K.; Durairaj, V. *The drivers of catastrophic expenditure: outpatient services, hospitalization or medicines?* Background Paper 21 to the World Health Report 2010.

Figure 5. Financial barriers to accessing treatment for women in rural and urban areas of the Asian, African and Latin American region, 2008 or latest available year



Source: DHS Macro International Inc., 2011. Measure DHS STATcompiler. Accessed 27.04.2011.

Generally, more women in rural areas report financial difficulties to accessing treatment than in urban areas. In the selected African countries, although inequalities in reported financial barriers between rural and urban areas are generally lower, women on average face greater barriers to accessing treatment compared to the other regions of the world. Large intra-country inequities are however observed in Sierra Leone, where 86.7 per cent of women in rural areas and 68.2 per cent of women in urban areas report difficulties in financial access, and significant inter-country inequities are found between Cambodia, Sierra Leone and Honduras (17.9, 18.5 and 19.8 per cent respectively).

To afford health-related OOP, households may use savings, borrow money, or sell assets. Table 1 is an example from Cambodia showing the various resources tapped for accessing health care.

Table 1. Sources for out-of-pocket expenditures on transport and health care in Cambodia (per cent)

	Wages/pocket money	Gift from relative/friend	Savings	Borrowed money /without interest	Borrowed money /with interest	Sold assets	Other
Male	45.6	4.9	30.5	5.7	8.1	2.6	2.5
Female	44.6	7	30.1	5.3	6.8	2.5	3.2
Urban	61	5.4	21	4.6	4.8	1.1	1.6
Rural	42.8	6.3	31.6	5.6	7.7	2.9	5

Source: Data from National Institute of Public Health, National Institute of Statistics Cambodia and ORC Macro, *Cambodia Demographic and Health Survey 2005*. Phnom Penh, Cambodia and Calverton, Maryland, USA, 2006.

According to the country's *Demographic and Health Survey*, in general, less women than men can rely on earned income and "pocket money" (44.6 per cent), or savings (30.1 per cent) to cover expenses for transport and health care, and more women receive money as a gift from relatives or friends.

In rural areas, less than 43 per cent are able to pay for care through earned income and "pocket money" compared to 61 per cent in urban areas, and more people rely on savings (31.6 per cent compared to 21 per cent in urban areas). More of the rural population has to

borrow money with interest (7.7 per cent compared to 4.8 per cent in urban areas) and almost three times as many must sell assets.

Particularly high financial barriers for rural women can be observed for utilization of health care during deliveries. Table 2 shows OOP reported by women surveyed in predominantly rural districts of selected African countries.

- In Kenya, OOP for a normal facility-based delivery (excluding transport costs) amount to 17 per cent of monthly household income, defined as catastrophic at a 10 per cent threshold.

- OOP for complicated deliveries are catastrophic in Kenya, Burkina Faso and Tanzania: they represent 35 per cent of monthly income in Kenya, and reach 16 and 10 per cent in Burkina Faso and Tanzania respectively. [20]

In Asia, significant rural/urban inequities also exist due to financial barriers:

- In rural areas of China, costs for giving birth were catastrophic in 2007 at a 10 per cent threshold of total household budget for the lower income group, which paid a mean of 13.1 per cent of annual household income on OOP expenditures. At the same time, rates of child and maternal mortality were twice as high in rural areas. [21, 22]

- In India, delivery costs have been found to lead to non-utilization of health services. Deliveries at public health facilities represent 16 per cent of households' health expenditures and are catastrophic at a 10 per cent threshold of total household budget, and represent 51 per cent at a 40 per cent threshold of disposable income. The latter includes almost all households of the two poorest deciles, who consequently do not access the required services. [23]

Table 2. OOP expenditures of women in predominantly rural areas for deliveries in per cent of monthly household income and source of money for treatment, selected African countries

	Costs for delivery in % of monthly household income		Source of funds
	Normal delivery	Complicated delivery	
Kenya	17	35	79% received money from immediate family
Burkina Faso	8	16	31% sold assets or crops 40% received money from immediate family
Tanzania	6	10	33% sold assets

Source: Perkins M et al., "Out-of-pocket costs for facility-based maternity care in three African countries". In: *Health Policy and Planning* 2009, Vol.24 pp. 289-300.

[20] Perkins, M. et al., "Out-of-pocket costs for facility-based maternity care in three African countries". In: *Health Policy and Planning* 2009, Vol.24 pp. 289-300.

[21] OECD, *Rural poverty reviews: China*. Paris 2009.

[22] Wagstaff, A. et al. 2009. *Reforming China's rural health system*. The International Bank for Reconstruction and development/The World Bank, Washington D.C. 2009.

[23] Bonu, S. et al. "Incidence and correlates of 'catastrophic' maternal health care expenditure in India". In: *Health Policy and Planning* 2009, Vol. 24 pp. 445–456 doi:10.1093/heapol/czp032.

The results of high levels of OOP are not only financial hardship, indebtedness and impoverishment, but this can also lead to lower or non-utilization of health services, which means there are higher unmet needs for care, particularly among women in rural areas.

- In **China**, for example, the high costs of seeking care have lead to decreasing utilization of consultations and inpatient services, despite the growing need for health care for chronic disease and hospitalization, e.g. among the aging female population. Furthermore, almost half of those seeking inpatient treatments discharged themselves early against medical advice. The rural population is particularly affected: in 2003, 75 per cent of respondents stated they were unable to cover related expenses. [24]

- In **Thailand**, the impact of non-utilization of health care due to financial barriers was more severe for people living in rural areas in general, and disproportionately affected women. For women in rural areas, there were 4.6 times more deaths than women in urban areas because they could not afford access to health care, compared to four times as many men in rural vs. urban areas. [25]

3.2. Geographical barriers: How easily can women in rural areas reach health services?

Geographical barriers associated with long distances, insufficient road infrastructure and lack of transport translate into costs for accessing health services and thus increase health care costs. Such costs can quickly escalate, particularly for patients who need to seek care regularly. [26] As well as direct costs of transport, there also opportunity costs, e.g. travelling time or loss of income.

Travelling long distances to the next health facility by vehicle is difficult in more remote areas where both public and private transport may not be readily available. For those people dependant on transport, e.g. in emergencies and those too frail to travel by foot (such as the elderly), insufficient infrastructure can substantially limit access to required health services and is often associated with high transport costs.

Typically, the rural poor therefore utilize health services in close proximity. These are often lower cost primary care facilities where specific drugs or services may not be available locally and referrals to higher level facilities require even further travel than to the primary care facility.

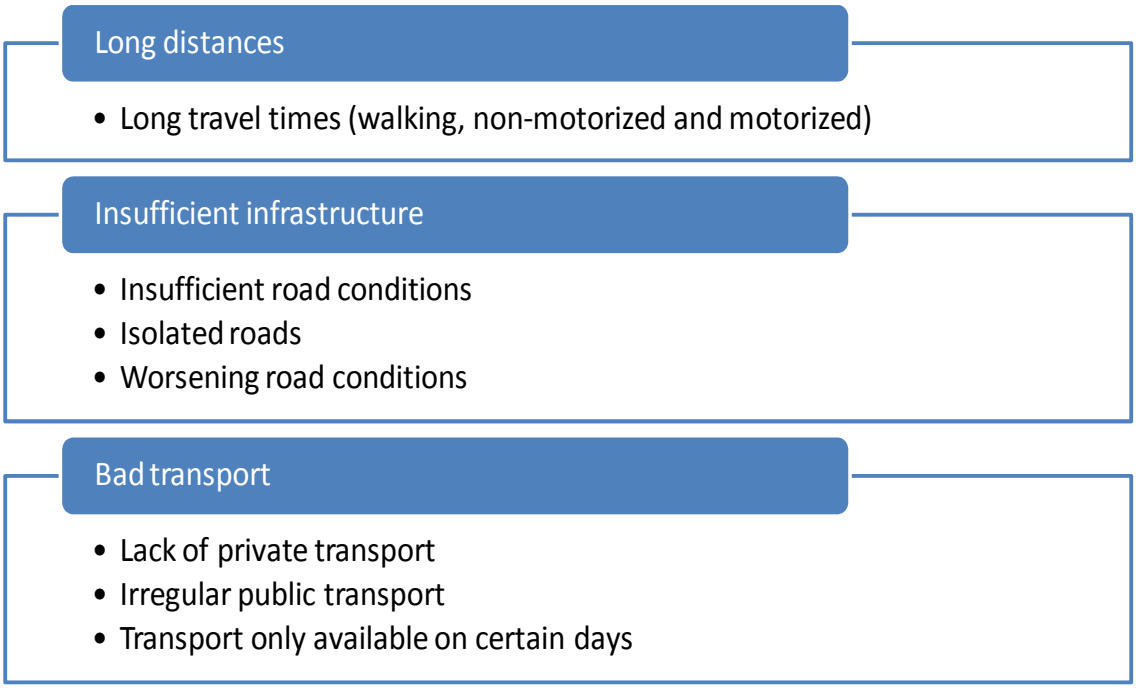
Figure 6 sets out examples of the geographical barriers to health care faced by women in rural areas.

[24] Wagstaff, A. et al. 2009, *Reforming China's rural health system*. Washington D.C.: The International Bank for Reconstruction and Development/The World Bank 2009.

[25] National Statistical Office Thailand. *The 2007 Health and Welfare Survey*. Available at http://web.nso.go.th/en/survey/hw/hw.htm

[26] Makawia, S. et al. *An assessment of the distribution of health services benefits in Tanzania*. SHIELD Work Package 3 Report, 2010. Available at http://web.uct.ac.za/depts/heu/SHIELD/reports/SHIELD%20BIA%20Report%20for%20/Tanzania.pdf [accessed 19.05.2011].

Figure 6. What geographic barriers must women in rural areas overcome to access health services?



Geographical barriers of access to health care play a role globally, including in the EU.[27] In many of the selected countries of the Asian, African, and Latin American regions, more than twice as many women in rural areas compared to urban areas report difficulties in obtaining health care, both in terms of distance and having to take transport (Figure 7).

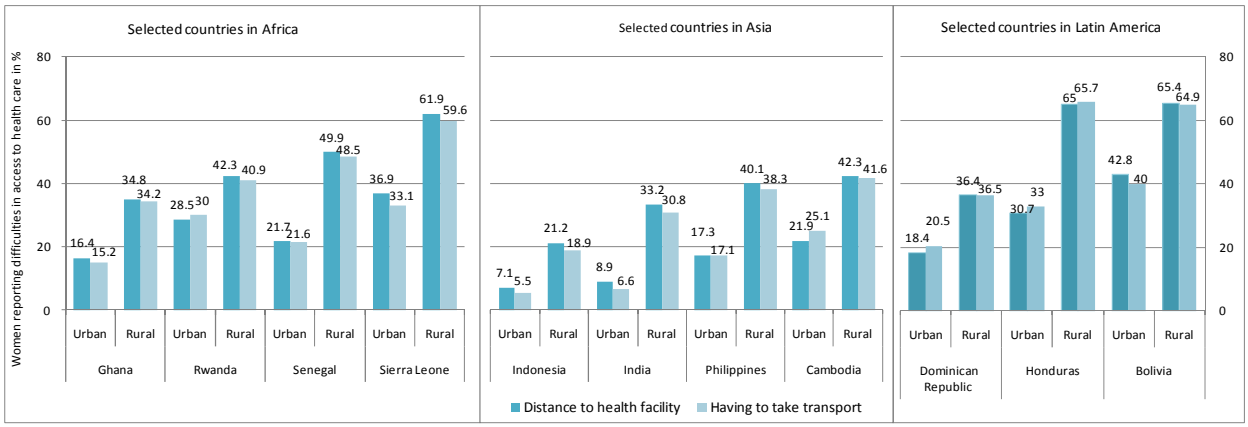
- In India, more than 30 per cent of women in rural areas report geographical barriers to access health care, compared to less than 10 per cent of women in urban areas.

- In Ghana, a similar trend can be seen where the related figures range around 35 per cent for women in rural areas and 16 per cent for women in urban areas.

In this context, transport costs play an important role. Figures 8 and 9 show the amount of **transport costs** in South African rand for delivery, antiretroviral therapy (ART) and tuberculosis (TB) services in selected rural (Bushbuckridge and Hlabisa) and urban (Soweto and Mitchell's Plain) health sub-districts in South Africa. In all districts, transport costs constitute a significant part of overall health care costs.

[27] EUROSTAT, *People with unmet needs for medical examination by sex, age, reason and income quintile (%)* (hlth_silc_08).

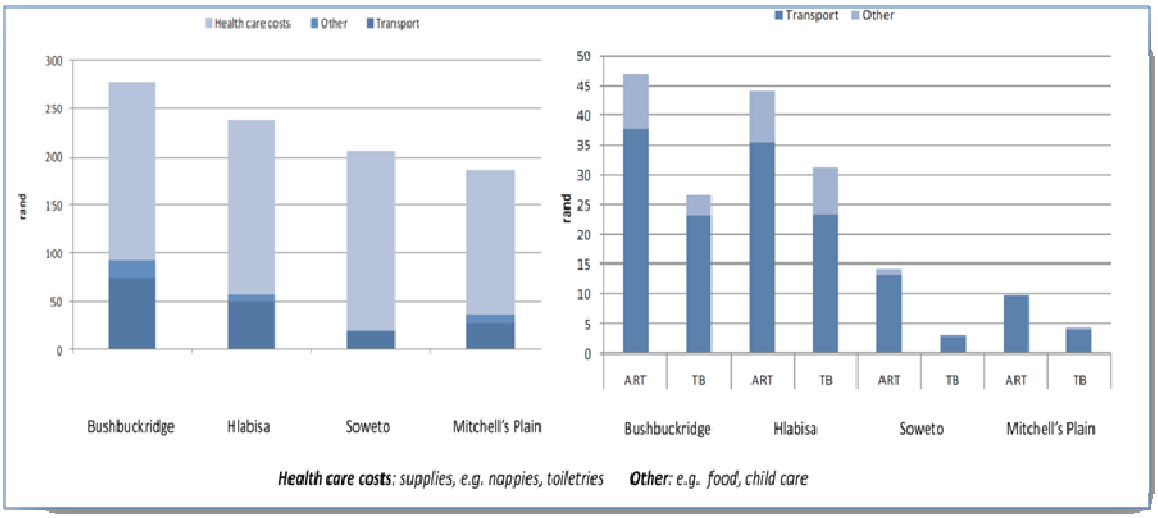
Figure 7. Geographical barriers in access to health care for women in rural and urban areas, of the Asian, African and Latin American region, 2008 or latest available year



Source: DHS Macro International Inc., 2011. Measure DHS STATcompiler. Accessed 27.04.2011.

Figure 8. Mean one way transport, health care and other costs of delivery in selected South African health sub-districts (in Rand)

Figure 9. Mean return journey transport and other costs of using ART and TB services in selected South African health sub-districts, 2008 (in Rand)



Source: Schneider H et al., Phase 1 Results: Access challenges in TB, ART and maternal health services. REACH (Researching Equity in Access to Health Care Project) Research report. Centre for Health Policy, University of Witwatersrand; Health Economics Unit, University of Cape Town; McMaster University, 2009.

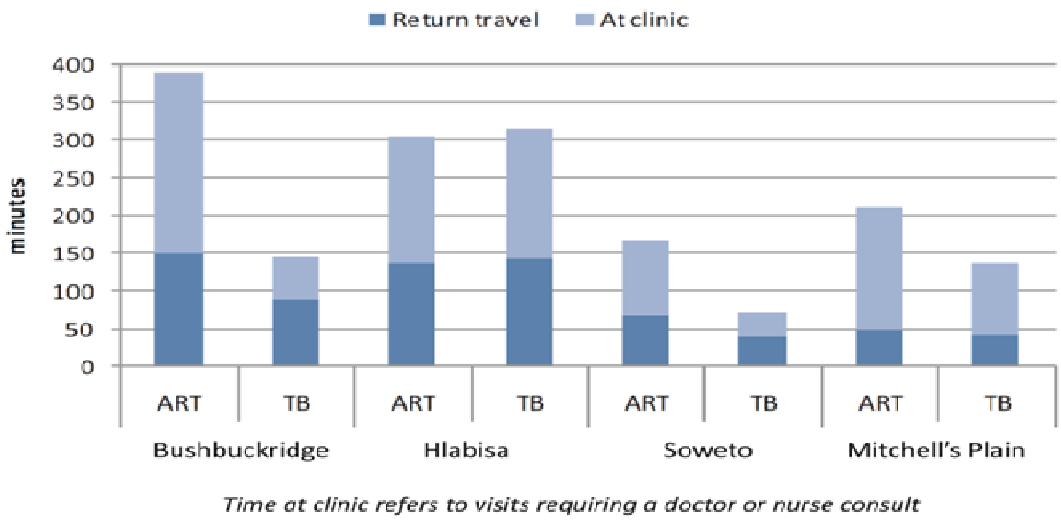
Women in rural areas often carry the triple burden of household and family care, subsistence agriculture and additional cash-generating activities.[28] **Opportunity costs** such

[28] IFAD, *Gender dimension of agricultural and rural employment: Differentiated pathways out of poverty*, Rome 2010.

as travelling time, waiting times and loss of productivity thus greatly impact on access to health care.

Figure 10 shows the amount of **time** spent seeking health care in terms of return travel and at the clinic when utilizing ART and TB services in South Africa. In rural Bushbuckridge, utilizing ART services takes an average of 6.5 hours. This is more than twice as long as for accessing ART care in urban Soweto. Both travel time as well as longer waiting times as a result of understaffed facilities can therefore impact on income generation and reduce accessibility to health care for women in rural areas.

Figure 10. Mean time in minutes required to use services in selected health sub-districts in South Africa



Source: Schneider H et al., Phase 1 Results: Access challenges in TB, ART and maternal health services. REACH (Researching Equity in Access to Health Care Project) Research report. Centre for Health Policy, University of Witwatersrand; Health Economics Unit, University of Cape Town; McMaster University, 2009.

3.3. Availability and quality of services: What is the impact of resource allocation for health care on rural women?

In many countries, resource allocation for health care is inadequate to meet the needs of women in rural areas. Due to a bias of allocation of public resources to urban rather than rural areas, rural women suffer from impacts on: [29]

- The availability of quality services due to the absence of health infrastructure and health workforce, including midwives; and
- Inequalities in financial protection.

Significant rural/urban imbalances of resource allocation can be observed in 2004 in China where total per-capita health care expenditure was four times higher in urban areas than in

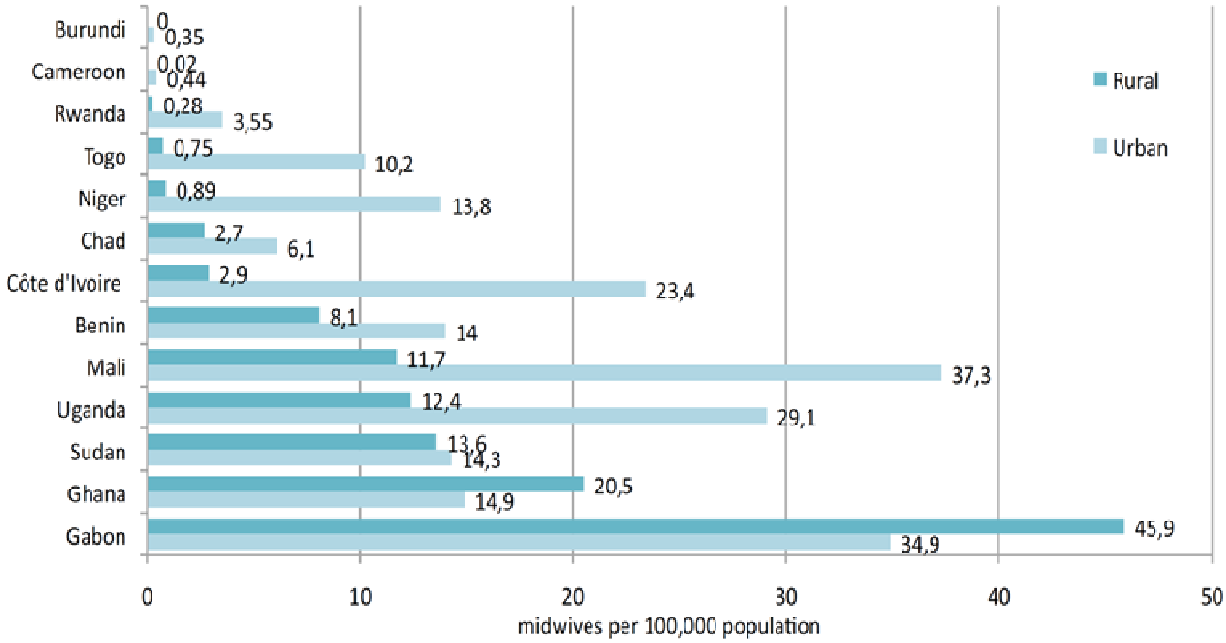
[29] Hsiao, W.; Heller, P. *What Macroeconomists Should Know about Health Care Policy*. Washington, International Monetary Fund, 2007.

rural areas. As a result, rural districts were disadvantaged in health infrastructure, quality of care and higher levels of financial protection that could be provided. [30]

Rural/urban inequities in allocation of financial resources to health care are not only due to policy making with regard to public funds. They can also be linked to a higher concentration of revenues of health facilities, e.g. through user fees in urban areas, where more people have the ability to pay. In addition, with health insurance being more wide-spread in urban areas, the flow of funds from health insurance is greater to urban areas than to rural areas. As a result, the allocation of health funds that is skewed towards the richer and urban population widens the gaps in the availability and quality of health care for women in rural areas.

The distribution of health care staff is also frequently skewed towards urban areas with direct impacts for rural women. Figure 11 provides insights into inequities in rural/urban distribution and density of midwives in selected African countries.

Figure 11. Rural urban distribution of midwives in selected African countries, 2004



Source: Based on authors' calculations using 2004 data on health workforce and 2005 population data, WHO, UNDP 2004/2005.

- Inequities are largest by a factor of 22 in Cameroon, where only two midwives are available to a rural population of over 8 million, and 43 midwives cover an urban population of 9.6 million.

- In Rwanda, Togo and Niger, the density of midwives in urban areas is close to 13, 14 and 16 times higher than in rural areas, where there are less than 0.3, 0.8 and 0.9 midwives per 100,000 population.

[30] OECD, *Rural Policy Reviews: China*. Paris 2009.

In Burundi, there were no midwives recorded in rural areas, and only 11 were counted in urban areas. This translates into less than 0.4 midwives per 100,000 population. It is only in Ghana and Gabon where the picture is reversed: the rural population is slightly better covered than the urban population (by 1.4 and 1.3 times as many midwives per 100,000 population).

It is only in Ghana and Gabon where the rural population is slightly better covered than the urban population.

As a result of a scarce health work force in rural areas, the attendance of a doctor at births is frequently lower in rural areas than in urban areas. [31]

- In African countries such as Niger, doctors attend 0.2 and 2.2 per cent of births in rural and urban areas respectively and in Sierra Leone 0.5 per cent compared to 4.7 per cent.

- In Asia, the largest gap is found in Cambodia, where 3.7 times as many births are attended by doctors in urban areas than in rural areas.

- In Latin America, a large gap is found, for example in Bolivia, where over twice as many births are attended by doctors in urban areas than in rural areas.

In conclusion, the distribution of human and financial resources is an important factor that contributes to inequalities of women's health care in rural areas compared to urban areas. It is impacting on the availability and quality of care for rural women and compromises rural women's effective access to health care.

[31] Data from DHS Macro International Inc., 2011. Measure DHS STATcompiler. Accessed 27.04.2011.

4. Social health protection: What are the systemic weaknesses for rural women?

While social health protection cannot substitute for policies that need to address gender inequalities in general, it has the potential to address gaps leading to inequities in effective access to health care if well designed.

Based on the ILO's definition, social health protection encompasses all public and mandated private measures against the social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earning or the cost of necessary treatment that can result from ill health. Social health protection – be it based on national health services, social health insurances, vouchers e.g. for maternal care or other mechanisms – requires legislation that aims at providing universal coverage for all citizens. Thus population coverage, or the existence of rights, is a prerequisite for equitable access to health care. The overall design of the scheme/system and its implementation are, however, additional factors that need to be taken into account when evaluating inequities for rural women.

Universal social health protection goes **beyond population coverage** in terms of formal rights to health care. To provide ***effective coverage*** for women in rural areas requires inclusive legislation that is implemented with a view to equity in access to health services. Services must be physically, financially and geographically available.[32] The scope of benefits should meet the specific health needs throughout the life-cycle in rural areas, and provide adequate financial protection.

Social health protection coverage is frequently provided by a combination of public schemes, social insurance, and private insurance. In low-income countries, community-based schemes or micro-insurance are also found.[33] The underlying design of related systems and schemes and related financing mechanisms are based on assumptions of "typical" socio-economic patterns, e.g. regarding the availability of income to pay for user fees or co-payments that might lead to inequities in access of those that do not match them.

Thus, some structural factors inherent in the design and financing of social health protection systems might constitute barriers that result in inequities and constitute systemic weaknesses. These are frequently related to:

- gaps in population coverage;
- gender-blind financing mechanisms of social health protection;
- scope of benefits and adequacy for rural women; and
- gender bias of social security systems beyond health.

In addition, overlooking interfaces of social health protection with other social security systems and their performance regarding rural women might constitute systemic weaknesses.

[32] ILO, *Social Health Protection. An ILO strategy towards universal health care*, Geneva 2008.

[33] Ibid.

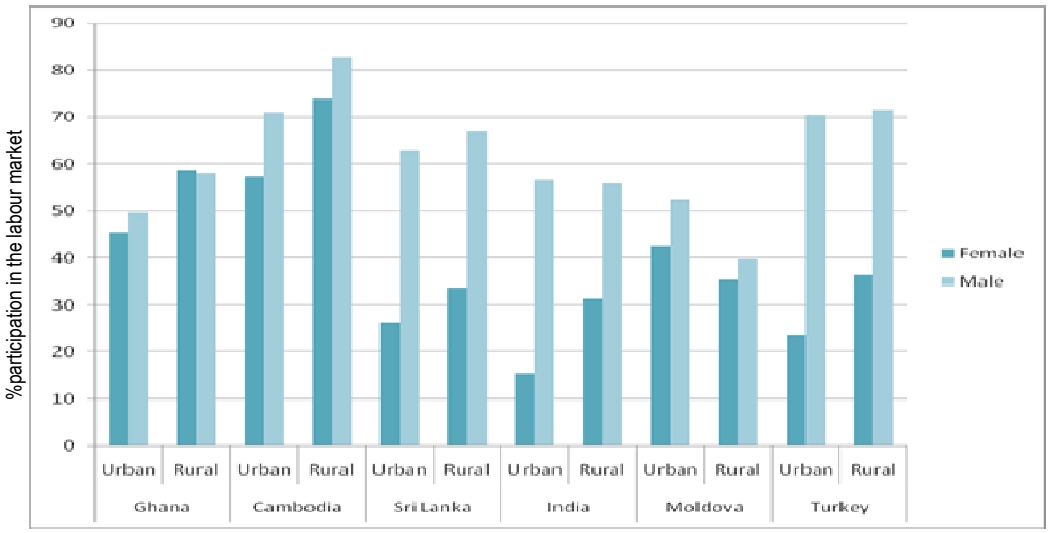
4.1. Gaps in population coverage

In many countries, population coverage in social health protection is linked to the fulfilment of specific **eligibility** criteria that might range from citizenship to formal employment contracts. Eligibility criteria are based on the assumption that the work and living conditions of everyone, as well as social norms impacting on them, are equal. These assumptions frequently disregard the situation of rural women which, in many countries is characterised by:

- *Lower labour market participation* compared to men in both rural and urban areas, such as in India where about 30 per cent of rural women participate in the labour market compared to some 55 per cent of rural men. (Figure 12) Furthermore, *unstable, fluctuating and irregular labour arrangements*, e.g. linked to migration, may equally impact on exclusion from social health protection.

- *Poverty, lower income* in rural areas than in urban areas as well as the gender pay gap and power *imbalances* in families impacting on control over resources. [34, 35]

Figure 12. Labour force participation by sex in rural and urban areas of selected countries, 2008 or latest available year



Source: Author, Data from National Labour Force Surveys.

These factors might result in exclusion from social health protection coverage because rural women cannot afford to pay for premiums or contributions, such as in Ghana where 17 per cent of rural women indicated that they did not register for health insurance because they could not afford to pay for premiums. Furthermore, if working abroad, e.g. as

[34] ILO, *Unleashing rural development through productive employment and decent work: Building on 40 years of ILO work in rural areas.* First Item on the Agenda of the Governing Body 310th Session, Geneva, March 2011. Available at:
http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_151847.pdf

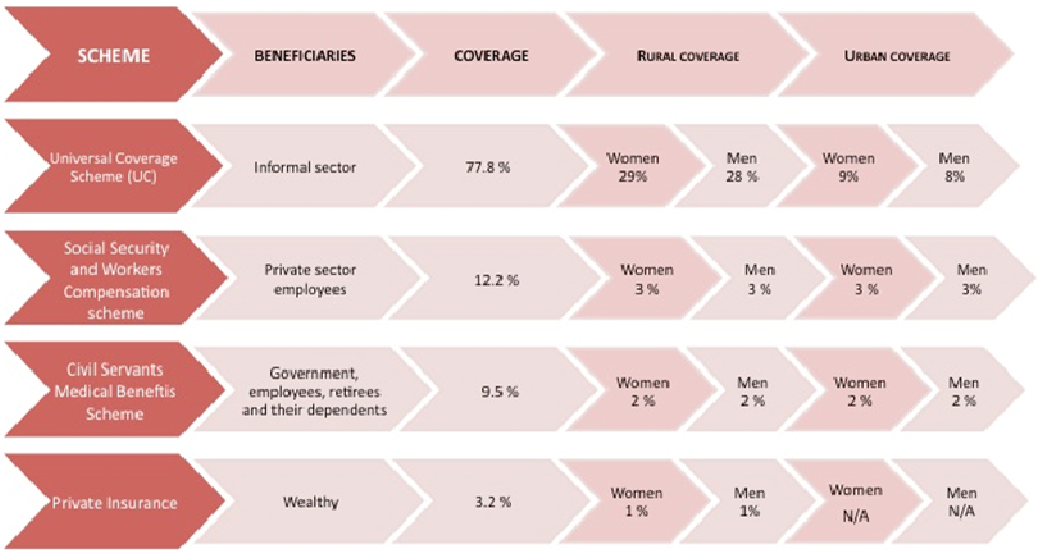
[35] FAO, IFAD, ILO, *Gender dimensions of agricultural and rural employment: Differentiated pathways out of poverty. Status, trends and gaps*, Rome 2010.

migrants, not being a citizen of the country in which they work might deprive women from the right to access national health services. [36, 37]

Countries that strive for universal coverage such as Thailand and Ghana have seen significant progress in achieving equal coverage rates between rural women and other groups of the population.

- In Thailand, a coordinated approach of four specific schemes for various population groups resulted in a nearly universal coverage of the whole population. As shown in Figure 13, the Universal Coverage Scheme (UC) for the informal sector provides coverage to 29 (28) per cent of women (men) in rural and 9 (8) per cent of women (men) in urban areas. Very low but nearly equal coverage rates between men and women are also found in the other schemes.
- In Ghana, population coverage through the National Health Insurance Scheme (NHIS) (Figure 14) is reported to be lower in rural areas (6.6 per cent) than in urban areas (10.8 per cent); however, more women than men are insured. In rural settings, 3.4 per cent of women are insured and 3.2 per cent of men are insured, whereas in urban areas 5.9 per cent of women and 4.9 per cent of men are insured. More women than men have also registered for the NHIS, although they remain uninsured until the payment of premiums and receipt of health cards. At the same time, more women than men report not being insured in rural areas (44.3 per cent) than urban areas (40.1 per cent).

Figure 13. Social health protection coverage for women and men in rural and urban areas of Thailand, in per cent of total population

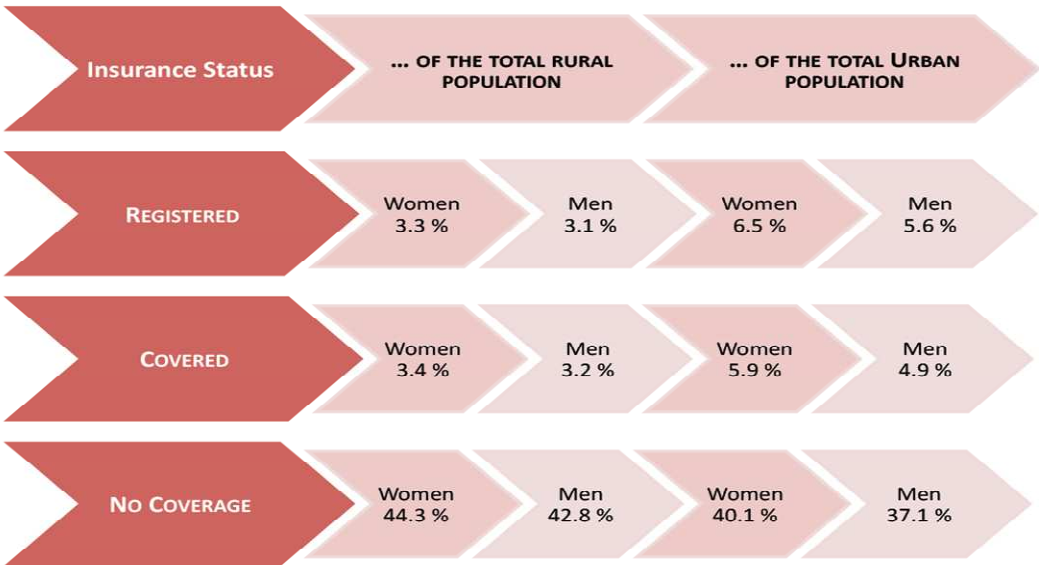


Source: Author, Data from National Statistics Office Thailand, The 2007 health and welfare survey. Available at http://web.nso.go.th.en/survey/hw/hw.htm [accessed 3.05.2011].

[36] FAO, IFAD, ILO, *Gender dimensions of agricultural and rural employment: Differentiated pathways out of poverty. Status, trends and gaps*, Rome 2010.

[37] WHO, *Women and health. Today's evidence, tomorrow's agenda*, Geneva 2009.

Figure 14. Population coverage by NHIS Insurance status of the total rural and urban population by sex, Ghana, 2008



Source: Author, Data from Ghana Statistical Service, Ghana Living Standards Survey (GLSS 5), 2008.

4.2. Gender-blind financing mechanisms

While the main financing mechanisms for health are based on taxes, payroll taxes or premiums, in almost all countries, co-payments, user fees and other expenditure that occurs at the point of health service delivery also play an important role in accessing health care. Such out-of-pocket payments (OOP) – as the most regressive method of health financing – can expose the sick to financial hardship and even impoverishment. While OOP decreased over time as a percentage of total health expenditure in all regions and even in low-income countries (Figures 15 and 16), at 40 to 45 per cent of total health expenditure, they still constitute a very significant amount that is particularly burdening the poor, including rural women given their limited income and control over resources available at household level.

Even for the most basic care, such as facility-based maternity care, OOPs occur, e.g. in Kenya, 98 per cent of all women had to pay some fees and in Burkina Faso 92.5 per cent of women reported paying fees. [38] These fees amounted to more than US $18, e.g. in Kenya, and thus constitute an important burden in a country where the average annual income is about $730, while most of the population earns less than $1 per day. [39]

[38] Perkins, M.; Brazier, E.; Themmen, E. et al., Out-of-pocket costs for facility-based maternity care in three African countries, Health Policy and Planning (2009), 24 (4): 289-300.

[39] World Bank, Data Kenya, 2011, Washington.

Figure 15. Out of pocket expenditure as a percentage of total health expenditure, by region, 1995-2009

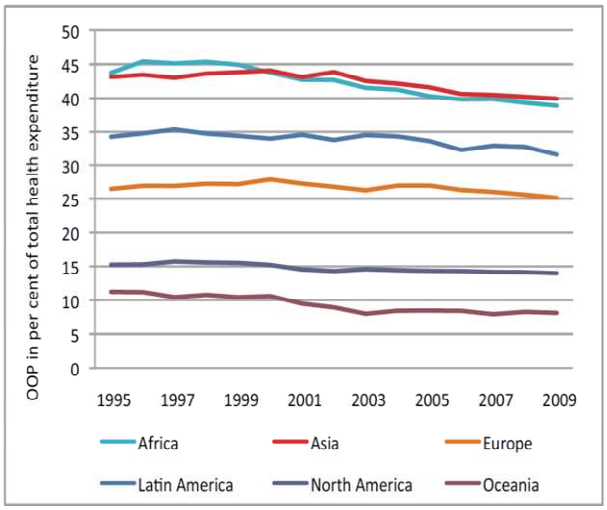
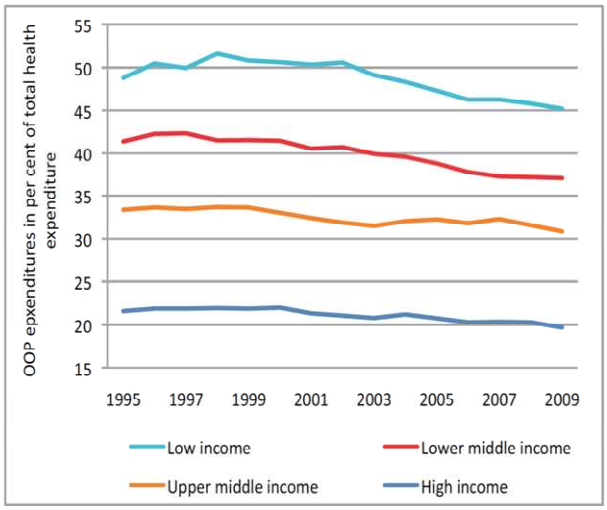


Figure 16. Development of OOP in per cent of total health expenditure by country income level, 1995-2009



Source: Authors, based on World Health Accounts 2011.

4.3. Scope of benefits and adequacy for rural women

Benefits in social health protection, including both cash and medical benefits, frequently do not match the needs of women.

Cash benefits, e.g. during sick leave, are supposed to replace gaps in income; however, globally all countries providing for income replacement during periods of sick leave have set a maximum period – in seven countries the maximum period is even less than seven days (Table 3).

Table 3. Periods of paid sick leave, global comparison, 2007

Number of countries providing for paid sick leave globally (total 145)	Maximum length of paid sick leave
102	One month and more
33	11 days to one month
3	Up to 10 days
7	Less than 7 days or unspecified

Source: Scheil-Adlung X. and Sandner L. Wage continuation during sickness: Observations on paid sick leave Provisions in times of crises. ILO Geneva, 2010.

Furthermore, in more than 50 countries, the minimum replacement rates of wages are limited to 50 per cent of wages (Table 4). These limitations therefore further impact on the already constrained income situation of rural women in many countries, and this is not even considering those women working without formal employment contracts, e.g. in the informal economy, who have no benefits at all.

Table 4. Minimum replacement rates of wages, 2007

Countries providing for paid sick leave (%)	Minimum replacement rates of wages (%)
21	100
14	75
51	50
14	N/A

Source: Scheil-Adlung X. and Sandner L. Wage continuation during sickness: Observations on paid sick leave. Provisions in times of crises. ILO Geneva, 2010.

(Conditional) Cash benefits that are sometimes provided to women are usually not designed to cover costs of health care needs but, for example, as a behavioural incentive to take up benefits that might be financed through other mechanisms. Cash benefits might therefore not be sufficient to cover, for example, OOP.

The scope of **medical benefits** is inadequate if the services covered by the health protection system do not correspond to the health needs of the beneficiaries, i.e. if particular services are not or are only partly covered. Despite the growing need for long-term care among women, related benefits are rarely available in lower-income countries. In addition, recurrent co-payments, such as clinic fees per visit, may not be included in the benefit package. If the scheme operates on a reimbursement system, financial barriers at the point of accessing care constitute barriers, and inadequate levels of reimbursement leave women in rural areas in financial hardship.

This situation has been observed in many countries such as in **India**, where for 15 per cent of insured women, hospital admission results in catastrophic payments even after reimbursement by the rural SEWA scheme.[40]

The New Rural Cooperative Medical Scheme (NCMS) in **China**, which specifically targets the rural poor and has increased access for the poor, also shows deficits in benefits. NCMS coverage rose rapidly from implementation in 2003 to 89.4 per cent in 2008, resulting in wider coverage than the urban scheme of 64.8 per cent the same year.[41] Through the provision of medical **maternity benefits**, the NCMS has substantially reduced OOP for caesarean sections by covering 40 to 50 per cent of related expenditures. Normal delivery is reimbursed through a fixed payment, but this has not been adjusted to rapidly increasing prices, also leaving a large gap in financial protection. For women of lower income groups in rural areas, this may present a severe financial burden. While OOP for a normal delivery amounted to 7.4 per cent of annual household income in 2007, they reached up to 31.8 per cent for caesarean sections. The mean cost of delivery amounted to 13.1 per cent, translating into catastrophic health expenditure at the 10 per cent threshold.[42] Inadequate benefits of the scheme are also related to a **focus on inpatient rather than outpatient care**: low benefit levels resulted in insufficient financial protection

[40] Tangcharoensathien, V. et al. "Health-financing reforms in Southeast Asia: challenges in achieving universal coverage". In: The Lancet 2011, Vol 377, pp.863-873.

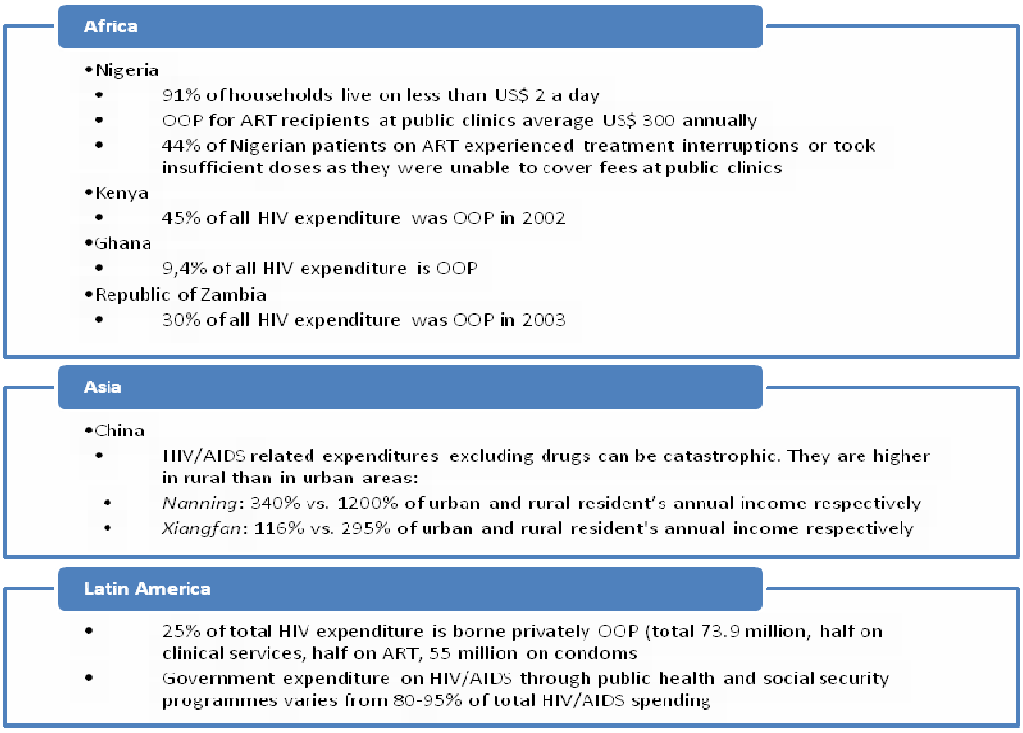
[41] National Health Services Survey 2008, ct. Meng Q and Shenglan T, *Universal coverage of health care in China: Challenges and opportunities*. Background Paper 7 to the World Health Report 2010.

[42] Long, Q. et al. "*Giving birth at a health-care facility in rural China: is it affordable for the poor?"* In: Bulletin of the World Health Organization 2011, Vol. 89, pp.144-152.

by reducing the incidence of catastrophic expenditures linked to outpatient treatment by merely one per cent. [43]

HIV/AIDS treatment is often excluded from benefit packages of social health protection schemes and instead is provided through vertical programs. Despite donor funding and the free provision of ARV drugs, service fees and other related costs such as hospitalization, counselling and testing, medical consultations, examinations, and laboratory monitoring are usually not covered and must often be paid out-of-pocket. [44, 45] For women in rural areas, such gaps can impact on utilization and continuation of care. Overall, such payments make up a substantial proportion of total HIV expenditure, e.g. in Kenya (45 per cent), the Republic of Zambia (30 per cent) and to a comparably lesser extent in Ghana (9.4 per cent). In Latin America, OOP average 25 per cent of total expenditure (Figure 17). [46] In China, HIV-related costs amounted to US $200-$3,939 per patient per year in Nanning, and to US $13-$1,179 per patient per year in Xiangfan in 2008. In Nanning, gaps in the scope of benefits translated into 1,200 and 340 per cent of the income of rural and urban residents respectively. In Xiangfan, OOP amounted to 295 per cent of rural and 116 per cent of urban annual income. [47]

Figure 17. Overview: Gaps in financial protection of HIV/AIDS



[43] Shi et al. "The influence of the rural health security schemes on health utilization in rural China: data from a household survey of western and central China". In: *International Journal for Equity in Health 2010*, Vol.9 No.7.

[44] Riyarto, S. et al. "The financial burden of HIV care, including antiretroviral therapy, on patients in three sites in Indonesia". In: *Health Policy and Planning 2010*, Vol. 25, pp.272-282.

[45] UNAIDS and WHO, *AIDS epidemic update: November 2009*, Geneva 2009.

[46] UNAIDS Global report: UNAIDS report on the global AIDS epidemic 2010, Geneva 2010.

[47] Moon, S. et al. "Out-of-pocket costs of AIDS care in China: are free antiretroviral drugs enough?" In: *AIDS Care 2008*, Vol. 8 pp. 984-994.

4.4. Gender bias of social security systems beyond health

As is the case with social health protection, other social protection systems such as income support systems for the poor and unemployed, pension schemes for the elderly, family allowances, education and housing suffer from significant defaults when it comes to covering women, particularly rural women, and providing access to related services.

- Structural barriers posed by accessing **employment-based schemes** that are based on the assumption of formal and long-term employment and the provision of wage-related benefits are reflecting the gender imbalances and amplifying inequities.

- In addition, universal or **targeted, e.g. means-tested, social assistance** type schemes face limitations when it comes to gender equity, particularly regarding rural women. While it might be assumed that more women might be covered and get access to benefits, the level of such benefits, as well as their quality, is frequently inadequate given the underfunding of related systems. This is particularly the case in times of economic and financial imbalances that constrain public budgets. Further, such benefits are often linked to stigma and tend to increase discretionary power (of authorities) on women.

As a result, inequities in social security expenditure for men and women can be observed even in high-income countries such as Austria. Data from Austria reveals that **less women than men benefit from social expenditures**, in addition to receiving **lower average benefits**. In 2006, despite higher female unemployment, total social expenditure for men was twice the expenditure for women.[48] This is mostly attributed to the disadvantaged position of women in the labour market, including a higher proportion of part-time employment.

Women receive significant support in their role as mother and carer for their family;[49] however, such systems, while most important for both rural and urban women, often perpetuate existing gender and rural/urban imbalances rather than addressing the root causes.

In many countries, the structural gender bias of social security systems impacts on institutions that are already financially and administratively weakened by persisting economic crises, capacity gaps and the absence of political will to progress with reforms, even as regards governance issues of existing social security systems. This is the case, for example, in countries of the broader European region and Central Asia where most important programmes for rural women such as social assistance, unemployment benefits schemes, family allowances and housing are at risk of being crowded out due to gaps in funding.[50] Such programmes are of critical importance for vulnerable groups such as rural women to mitigate inequities in access to health care, especially in countries such as Azerbaijan with extremely low health expenditure of 0.86 per cent of GDP or 0.95 per cent of GDP in Tajikistan.[51]

[48] Steiner, H. "13. Sozialausgaben", in: Bundesministerium für Soziales und Konsumentenschutz, Österreich., Sozialbericht 2007 – 2008. *Ressortaktivitäten und sozialpolitische Analysen*, pp.159-189, Wien 2009.

[49] ILO, World Social Security Report 2011, Geneva.

[50] ILO, *Facts on social protection in Europe and Central Asia*, Geneva, 2009.

[51] Scheil-Adlung, X.; Kuhl, C. Addressing inequities in access to health care for vulnerable groups in countries of Europe and Central Asia, ILO Policy Brief, 2011.

5. How to address issues in access to health care for rural women?

As shown above, there are significant inequities in coverage of and access to health care for women living in rural areas compared to urban areas, and for women compared to men. These inequities impact on the human right to health and progress towards the MDGs. Furthermore, access barriers for women living in rural areas impact on the utilization of health services throughout the course of their lives. They are frequently linked to:

- **Inadequate population coverage** due to eligibility criteria that are frequently excluding rural women such as formal employment;
- **Deficits in financial protection**, mainly of OOP, and loss of income due to sickness and maternity;
- **Limited scope of benefits** that do not match the health needs of women in rural areas; and
- **Gaps in the availability of health services** in rural areas compared to urban areas due to inadequate infrastructure, health work force distribution and density.

The root causes of the inequities observed are complex and cannot be addressed by social health protection alone. In addition, it is important to impact on the broader socio-economic environment such as employment, income and poverty.

Thus, effectively eliminating issues in access for women in rural areas requires a coherent policy approach in the health, social and economic sectors, including embedding social health protection in an effective and efficient national social protection floor.

Social health protection policies should ensure that an inclusive legal framework is implemented and leads to effective access to health care for rural women. Such a framework will have to:

- Close gaps in population coverage arising from discriminatory practices, including eligibility criteria such as allowing for the inclusion of various types of work rather than exclusively work based on formal employment contracts and individual rather than household coverage;
- Introduce gender aspects into budget allocation and assessments and gender specific targets for expenditure on the social health protection of women; and
- Adjust benefit packages with a view to protecting women regarding their financial and medical needs.

Related regulations should be supported by effective governance based on vision and strategic direction on inclusiveness of rural women. This involves social dialogue and regular monitoring of progress. Furthermore, funding gaps, low quality of care and health work force deficits in rural areas should be addressed with priority.

Such policies should be closely coordinated with coherent social and economic policies. In particular, this includes raising the overall social protection floor for vulnerable rural women, e.g. through providing decent living wage, income security and benefits in kind and in cash for women in rural areas to mitigate impacts of poverty, unemployment, old age, maternity etc. Furthermore, supportive policies should also be established with a view to:

- Increasing female labour market participation;
- Eliminating discriminatory wages;
- Enhancing women's employment guarantees in times of economic crises;
- Improving skill development and access to education for women in rural areas; and
- Supporting the transition from the informal to the formal economy.