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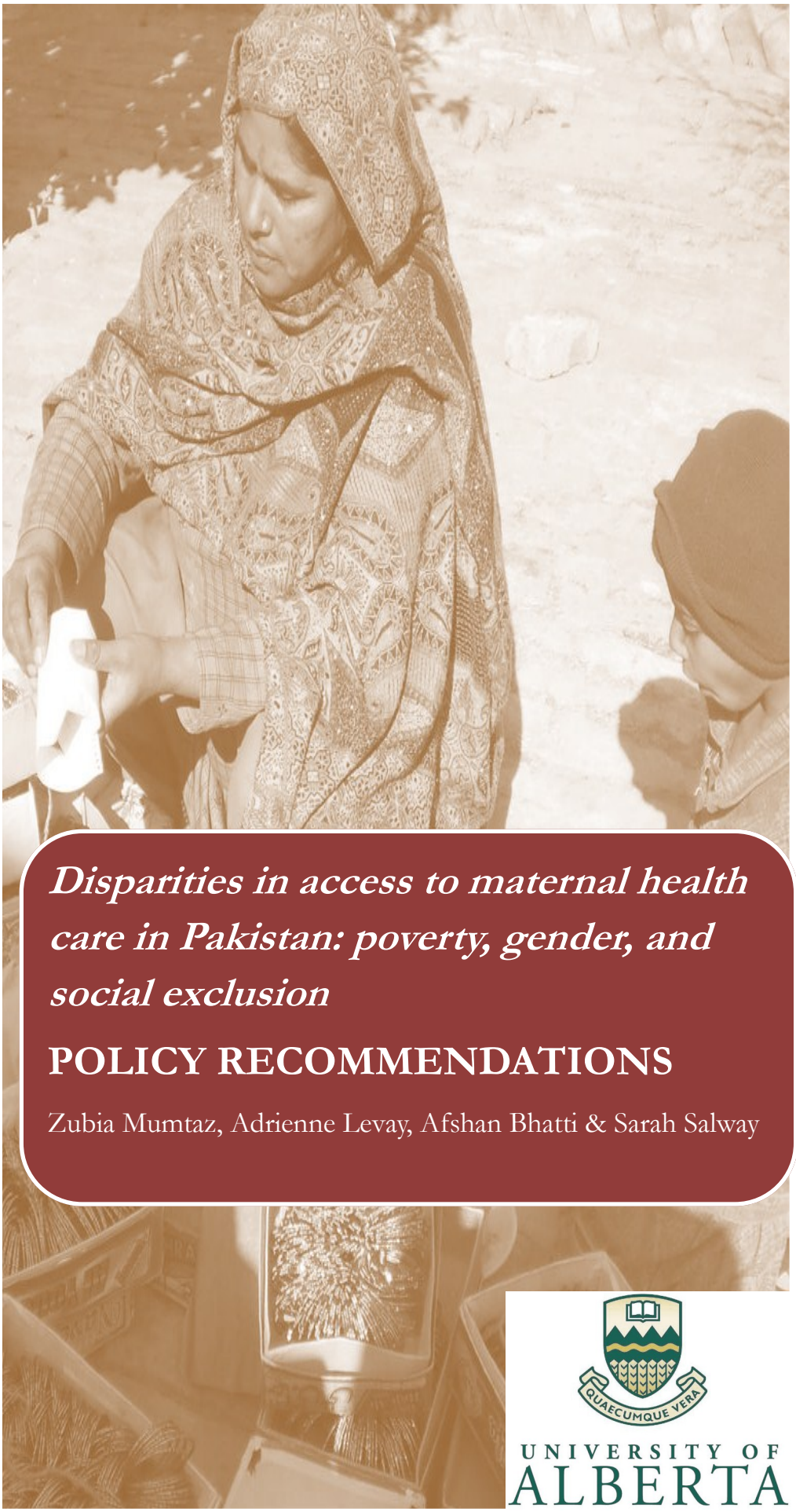

Disparities in access to maternal health care in Pakistan: poverty, gender, and social exclusion

POLICY RECOMMENDATIONS

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Social exclusion and Maternal Health: Policy recommendations

Who is this briefing for?

This briefing is for policy-makers , program managers and donors concerned with the poor status of maternal health in Pakistan.

Why is this important?

Despite increases in uptake of maternal health services following the implementation of a number of strategies in Pakistan, the gap in use of services between the rich and poor is widening.[1,2] The following policy recommendations are based on the findings of our research project which argue that one major reason for this widening gap is that well-intentioned interventions have not been developed with an in-depth understanding of who exactly are the poor, socially excluded women and how they are often excluded by the health system.

Table 1: Summary of key problems and recommendations

Problem	**Policy Recommendations**
1. Poor, socially excluded women and their families are invisible and silent.	Use indicators of social exclusion that sensitively reflects what it means to be socially excluded in Pakistan (see Table 2, next page).
2. Socially excluded people are landless, do not have access to education and stable cash- income generating opportunities.	Maternal health programs must take into account the unique social and financial constraints of people who are not paid in cash
3. Socially excluded women tend to be members of the *Kammi* caste. *Kammis* are socially constructed as inferior and stigmatised, justifying their abuse within the health care system.	Challenge the stigma associated with the *Kammi* caste through on-going sensitization and training of health care professionals.
4. The poorest, socially marginalised women are excluded from formal government entitlements (such as BISP).	Implement improved strategy for distribution of BISP transfers. Aim to eliminate preferential treatment for people with political connections.
5. Recent improvements in quality of public sector services has led to increased uptake by the rich. The poor remain excluded.	Develop incentives for poor, socially excluded women to seek facility care. Reduce the social and financial barriers the poor face, including abusive providers and corrupt practices.
6. Women and children working in *Bhattas* (brick kilns) are completely excluded from even basic maternal and child health services.	Ensure *Bhattas* are included in LHW catchment areas Ensure legislation outlawing bonded labour is enforced.

1. Poor, socially excluded women and their families are invisible and silent.

- Poverty is stigmatizing and the poor **avoid** being identified.
- Traditional indicators of poverty are most often limited to material assets like type of housing and ownership of items such as bicycles and TVs.
- Because of the invisibility of lower caste women and their families, effective indicators to sensitively identify them are necessary

Policy recommendation: Use indicators of social exclusion that sensitively reflect what it means to be socially excluded in Pakistan

Table 2: Potential indicators of poverty and social exclusion

Useful Indicators	Potentially Misleading Indicators
Individual's caste (*zaat or quam*) - Members of the *Kammi* caste are more likely to be socially excluded. Castes can be identified by surnames.	**Rural/urban residency**. Not all rural residents are poor and not all urban residents are wealthy
Ownership of agricultural land	The **type of dwelling construction** or availability of amenities (such as a toilet) as in many cases, the ultra-poor are allowed to live in houses owned by the rich land-owners as payment in-kind. Some of these houses maybe *pucca*, well built houses, but this not reflective of the socio-economic status of the dwellers.
Ownership of land on which their house is built	**Ownership of the house if they do not own the land on which it is build.** Often *Kammis* are lent land (as payment in kind) to build their homes, but they be can be evicted at the whim of the landowner.
Occupation in the village (low caste occupations include butchers, barbers, carpenters, agricultural and domestic labour)	**Unemployment status of men** in the family. Many high caste men refuse to work in occupations they consider low status because doing so will comprise their and their *biradaris* prestige and reputations.
Type of remuneration for work done: Are they paid in kind or in cash?	**Whether or not they are officially enrolled in poverty alleviation benefit programs**
Women and children of the family working as agricultural labours on lands that do not belong to them or as domestic servants in other peoples houses	**Women who work on their family lands.** In households with small land holding women will work during planting and harvesting.
Work and residence in a *bhatta* (brick kiln).	**Who the villagers identify as poor.** The upper castes and elite villagers will usurp the conversation, will self-identify as poor while the true poor will not identify themselves for reasons of shame and stigma.

2. Socially excluded people are landless, do not have access to education and stable cash- income generating opportunities.

- Socially excluded people are often bound in social contracts with the landed higher caste families via the *seph* contract in which they are paid annually in-kind with wheat and clothes.
- The dominant strategy of many current maternal health interventions is the promotion of saving money for childbirth (birth preparedness and complication readiness).
- The idea of saving for childbirth was well known among all castes within the village. However, poor, lower caste families did not have sufficient incomes to save money.

***Kammi* men from the *nai* sub-caste cooking for a wedding**

Policy recommendation: Maternal health programs must take into account the unique social and financial constraints of people who are not paid in cash

3. Socially excluded women tend to be members of the Kammi caste. Kammis are socially constructed as inferior and stigmatised, justifying their abuse within the health care system.

- There is a widespread denial of the deprivation the *Kammi* people face by the upper caste members of society, generally.
- In Pakistan, the caste system is the 'elephant in the room'[3] and has been 'swept under the rug'. However, Mohmand and Gazadar[4] show in a national survey of the social structures in rural Pakistan the importance of the role of caste in daily life, economics and politics, further exacerbating social exclusion of women and their families.
- Policy-makers must recognize that healthcare organizations replicate a society's social system.
- Health care professionals are held in high esteem and therefore have a responsibility to use their skills and influence to change the poor and abusive attitudes of themselves and their colleagues.
- Medical professionals must be sensitized during both their foundational education and also at regular intervals throughout their professional careers on their role in the perpetuation of poverty and social exclusion. They must also be educated on their potential roles in alleviating poverty and social exclusion.

Policy recommendation: Challenge the stigma associated with the *Kammi* caste through on-going sensitization and training of health care professionals.

4. The poorest, socially marginalised women are excluded from formal government entitlements (such as BISP).

- The procedure by which BISP money is distributed is highly flawed. It ensures the beneficiaries are either selected on the basis of political patronism or on the advice of community members who do not recognize and acknowledge the poverty and vulnerability unique to the *Kammi* caste members.
- Our assessment indicated that half of the current BISP beneficiaries in the village field site are not-poor.

Policy recommendation: Implement improved strategy for distribution of BISP transfers. Aim to eliminate preferential treatment for people with political connections.

\5. Recent improvements in quality of public sector services has led to a disproportionate increase in use by the rich. The poor remain excluded.

- Overall, 36% of the births in the village took place in public sector facilities. Amongst the highest caste, wealthy landowners, 55% percent of births took place in a public sector facility.
- In contrast, only 29% of *Kammi* births took place in a public sector facility.
- *Kammi* women identified abusive health provider behaviour as the key reason for avoidance of public sector health facilities

Policy recommendation: Develop incentives for poor, socially excluded women to seek facility care. Reduce the social and financial barriers poor face, including abusive providers and corrupt practices.

6. Women and children working in Bhattas (brick kilns) are completely excluded from even basic maternal and child health services.

- Bonded labour in Pakistan is illegal but a blind eye has been turned to the resilience of this institution currently existing at brick factories (*bhattas*).[5]
- The workers in these brick kilns (women, men and children) are bonded labourers who work under unacceptable conditions.
- The government does not provide basic services to those living in these brick factories, including routine primary health care services. *Bhattas* are not even included in the Lady Health Worker's catchment areas and our data show that no 'self-respecting' LHW would be willing to venture into a *bhatta*.

Policy recommendation: Ensure *Bhattas* are included in LHW catchment areas

Ensure legislation outlawing bonded labour is enforced.

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