

**INTERACTION BETWEEN MALE DOCTORS AND FEMALE  
PATIENTS: CULTURE AS A BARRIER IN ACCESS TO  
HEALTH CARE**

*A Study of Peshawar District, Khyber Pakhtunkhwa*



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**CERTIFICATE**

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### **Author's Declaration**

I, Sahibzadi Faiza Noor, hereby state that my MPhil thesis titled "Interaction Between Male Doctors and Female Patients: Culture as a Barrier in Access to Health Care; A Study of Peshawar District, Khyber Pakhtunkhwa" is my own work and has not been submitted previously by me for taking any degree from Pakistan Institute of Development Economics or anywhere else in the country/world.

At any time if my statement is found to be incorrect even after my Graduation the university has the right to withdraw my degree.

  
Sahibzadi Faiza Noor

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This piece of work and therein all the knowledge and understanding that I acquired through it, is  
dedicated to my beloved (father) Baba

**Squadron Leader (Retd.) Sahibzada Sajjad Noor**

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## LIST OF ACRONYMS

BHU	Basic Health Unit
DG	Director General
FATA	Federally Administered Tribal Areas
FLCF	First Line Care Facility
GP	General Physician
IUD	Intra Uterine Device
KPK	Khyber Pakhtunkhwa
LHV	Lady Health Visitor
LHW	Lady Health Worker
MA	Medical Assistant
MT	Medical Technician
NWFP	North West Frontier Province
OPD	Out-Patient Department
RHC	Regional Health Center
UTI	Urinary Tract Infection
WEF	World Economic Forum

## GLOSSARY

**Basic Health Unit** - primary health care center in rural and suburban areas of city opened with the objective of providing first line defence against minor ailments and to increase access to basic preventive health care services particularly in rural areas.

**Beemari** - common illness

**Chachi** - of female gender, meaning paternal uncle's (chacha) wife, commonly used to infer Aunt

**Haji** - a person who has performed religious pilgrimage *Hajj*, a religious person

**Haya** - modesty, shyness

**Jan** – an endearing word meaning dear or darling

**Lady Health Visitors** - provide services to urban and rural communities, in basic nursing care, maternal child health services, and training of community workers.

**Lady Health Workers** - deliver services related to maternal and child health, immunization, growth monitoring, family planning and health promotion. They treat minor ailments and injuries and are trained to identify and refer more serious cases

**Likorea** - also called PV discharge, a common gynaecological disorder having abnormal discharge from genital tract

**Mehram** - A blood relation or kin with whom marriage cannot take place like father, brother, son, father-in-law, grandfather, uncle etc. for female and mother, daughter, sister, mother-in-law etc. for male.

**Purdah** - veil worn by a female for physical seclusion from men.

**Secondary level hospitals** - District headquarters hospital (DHQ) or tehsil headquarters hospital (THQ) usually at district level established for out-patients and inpatients and for providing some specialist care.

**Sharam** – shame or shamefulness

**Soni** – an endearing word meaning pretty or sweet

**Tertiary level hospital** – government referral hospitals that offer services from specialists in a large hospital

## ABSTRACT

In traditional and pluralistic societies like Pakistan, health care system needs to be sensitive towards the religious and cultural norms of the patients. If such cultural sensitivities are overlooked, the resultant cultural discordancy between the doctor and the patient may lead to poor diagnosis and patient dissatisfaction. Although a lot of work has focused on doctor-patient relation, the available literature overlooks the cultural influence on the effective communication in the given medical dyad. Hence, the objective of this study is to fill the gap in literature and analyze the cultural effects on medical interaction between the female patients and male doctor. This explanatory study therefore, seeks to build on the available literature of the effects of gender-discordancy on interaction between patient and physician and explore further the aspect of culture effects on female patients and male doctors.

By applying thematic analysis framework to the data, the research analyses the cultural barriers or challenges faced by the female patients in the primary health care units. A field study was conducted on primary health care centers in the district of Peshawar and information was gathered using purposive sampling, from male doctors, female patients and medical staff available in the basic health centers. The study found that majority of patients visiting the primary health care centers are females whereas the doctors available on duty are mostly male. Culture as an over-abiding factor makes it challenging for the female patients to get access to health services with male doctors. This situation leads to patients getting treated at parallel informal health sector by untrained healthcare providers. Since these primary health centers are established as first line care facilities for mother and child, it is essential that a certified female physician should be available at these BHUs to cater to health needs of the local people. It is thus, strongly desired that the concerned health authorities and the government be sensitized towards the cultural norms and values of the local people and provide them with basic health needs that could deliver better health results and improve health status of women.

Key words: culture, purdah culture and communication.

# CHAPTER 1

## Introduction

Health embraces an integral part of our lives. It is indispensable to life. Maintaining sound body and health is just vital to being alive. We are all potential patients! We interact with diseases, fall sick or may be found wanting in good health. The existence of health institutes and health seeking behaviour therefore occupies important part in our social lives particularly in our part of the world.

Pakistan is home to a thriving population of 207.774 million people (Population Census, 2017), with a traditional society having a rich milieu of sociocultural values and norms. There is a clear divide between the rural life with 64 percent of the population and the urban life with approximately 36 percent of the population (ibid). The family unit structure is the core or nucleus of the social structure in Pakistan. Islam being the dominant religion plays a central role in the public and private dealings of people from all social strata. The relation of the State with the religion is inextricable and no activity is considered secular in the life of a Muslim person. Moral authority and sense of right and wrong are directly derived from Islamic teachings and its tenets (Moazam, F, 2000).

In traditional societies like Pakistan, the health care system needs to be sensitive towards the cultural, religious and social backgrounds of the patients. If these traditional intricacies are overlooked, the resultant cultural discordancy between doctors and patients may lead in misdiagnosis and patient dissatisfaction (ibid).

Culture occupies an integral part in public health sphere. Moreover, public health and health communication have come to recognize the importance of cultural sensitivity in delivering effective health interventions (Kreuter & McClure, 2004). Culture manifests itself in all aspects of human life; the surroundings we live and respire in, our diet, attire and lifestyle etc. are all moulded by the cultural environment we are part of. Cultural beliefs direct our health seeking behaviour, our perspective of illness and antidotes we seek for relief of pain and distress (Ayonrinde, 2003). Cultural sensitivity in patient care

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is associated with a number of positive health outcomes including improved patient satisfaction and better compliance (Kreuter & McClure, 2004).

There is no dearth of information on the recognition of culture in medical care. Similarly, a large amount of literature is available on the on doctor- patient relationship, analysing it from various aspects. Yet the work done on physician-patient relation overlooks the influence a culture exerts on effective communication between the two (Ferguson & Candib, 2002). The discourse on effect of gender difference between patient-doctor in healthcare communication also inadvertently overlooks the question of how a female patient interacts with gender-discordant physicians - male doctors (ibid). This opens ground for analysing and studying interaction between female patients and male doctors with culture as a barrier in access to healthcare.

Judith Gray (1982) observes in her study 'The Effect of the Doctor's Sex on the Doctor-Patient Relationship' that much has been recorded on the interaction between doctor and patient but surprisingly little is known about whether the gender of the physician make any significant difference. She further explores that previous studies on gender difference had taken only the patient's gender into account; while the doctor was taken as a professional only – neither male nor female. The author acknowledges the importance of finding out whether the relationship between female physician and their patients is any different from that of male doctors and their patients. This difference is crucial for us to find out because female doctors are at the advantage of knowing and offering more than their male counterparts in the field (Gray, 2000). This point reinforces our position on patient-physician interaction, taking gender discordancy and culture in account.

Female physicians are found to be (more) empathetic and attempt to nurture positive relationship with their patients and especially female patients than their male colleagues. Moreover, female physicians are observed to devote a little more time on average to female patients, while male physicians are found to spend the least amount of time with female patients (Roter, D; Lipkin, M. & Korsgaard, A, 1991).

## 1.1 Key Concepts

### Culture

The definition of culture abounds so much in literature that it has become almost indefinable. However, for the purpose of this study which has underpinnings on culture, a working definition of the concept has been produced. Culture is the overall accumulation of ideas, beliefs, values, social norms and material objects that the members of a society use in dealing with one another and with rest of the world. These shared beliefs, values and customs are passed on from generation to generation in a society. (Leininger, 1970) & (Bailey, 1987).

The concept of culture is one of the overriding themes of this study. This research understands culture as a set of beliefs and values in a society that have been carried over generations over a long period of time and are used by the members of the society while dealing with one another especially with the opposite gender.

### Purdah

*Purdah* is from Persian word meaning veil or curtain. It is a religious and social practice and a symbol of female seclusion prevailing in many Muslim communities in South Asia and beyond. *Purdah* is observed in two forms: the physical segregation of the females from the males and secondly, the requirement for women to cover their body in a way to conceal their skin and shape (Purdah, n.d.).

*Purdah* results in curbing on women's mobility and serves as an inhibitor leading to their physical and social seclusion (Michael et al. 2003). This puts women in vulnerable position viz-a-viz the society, husband and in-laws. Studies suggest a strong and positive correlation between *purdah* and domestic violence (ibid). Restraint on female mobility also limits their ability to access health care and family planning services. In Pakistan, especially in the rural and suburban areas, unmarried girls and women face difficulties in access to health facilities on their own in villages due to *purdah* culture. Along the same vein, women had to be accompanied by a family member while visiting health centers outside their villages (Khan, 1999).

This hampers their chance of getting better health service delivery and improved health status. This research study defines purdah as the practice of womenfolk especially in KPK area to be covered physically in long attire while leaving their home steads with special reference to their physical segregation from opposite gender outside their family, their limitation on mobility and access to health services and the need to observe modesty while dealing in public spheres and in communication.

### **Communication**

Communication is a process of sharing information with the purpose of creating mutual understanding. When two people communicate, the message received, perceived and interpreted is according to each person's cultural conditioning and their cognitive ability which is shaped over the years through learning and experiences (Velentzas & Broni, 2004). The study envisages communication process as the information sharing between two individuals. It also includes features of communication as defined by Hargie & Dickson (2004) in the later section. Language, used in verbal communication is deeply ingrained in the particular culture of a speaker and does not carry a single universal meaning. Similarly, it is not possible to understand culture without its language and vice versa. Language plays an important role in creating the context of negotiation and in allowing negotiators to prepare for cross-cultural interactions. In the context of my research I have adopted the above conceptual definition

### **Cultural Barriers**

Cultural barriers are taken as the diverse religious, tribal and cultural differences that exist in a population which could negatively affect or de-facilitate one group, or gender due to the existing norms of the society (Ali, Bhatti, & Kuroiwa, 2008). The term cultural barrier has been understood by the study in the same manner as defined here. Further the concept shares similar feature as explained by Culture as a Barrier for Female Patients in later section. The inability of women to travel alone to the healthcare center as and when they desire is considered an important barrier in improving their health status. Similarly, majority of women visit the health facilities only when accompanied with the male members of the family (Mumtaz & Salway, 2005; Piet-Pelon et al., 2000). In a

traditional and conservative society like Pakistan, female patients clearly feel uncomfortable and shy away from discussing health issues particularly female problems with male doctors.

### **Gendered Clinical Interaction**

Physician – patient interaction lies at the core of shared decision-making process. The patient- physician gender and their concordance or discordance act a barrier or facilitator in their communication style. Gender differences in communication styles between clinicians and patients have been studied variously and claimed to influence patient health care (Wyatt, et al. 2014)

### **1.2 Statement of the Problem**

Despite the growing presence of female gender in medical and healthcare services not much attention has been given to the significant effects of culture on the gender difference between patient and physician (Roter, Lipkin & Korsgaard, 1991). More well-known documents highlight culture as an integral part of health care system and the effects of socio-economic level of patients in shaping patient-physician interaction. It is worth mentioning that culture as a barrier for female patients in their medical consultation with male physicians especially with respect to Pakistan and its rural areas has not received its fair share of attention. I, therefore, contend to analyze the influence of culture as a barrier for female patients interacting with male doctors in access to basic health care utilization.

There is a need to critically review the cultural influences on medical interaction between female patients versus male physicians.

### **1.3 Research Question**

The study is guided by a single fundamental question:

Is culture a barrier for female patients in access to healthcare services during their interaction with male doctors?

#### 1.4 Research Objectives

Following objectives were proposed for this research study:

1. To determine if our culture poses itself as a barrier and refrains female patients from having easy access to basic health care.

Culture norms predispose women to be examined by female doctors only, whereas the unavailability of the latter makes access to basic healthcare for females a problem. The religious, tribal and cultural barriers all combine together in form of social inaccessibility of health services and have major role to play in traditional society like Pakistan for <sup>prompt</sup> healthcare delivery and utilization plans.

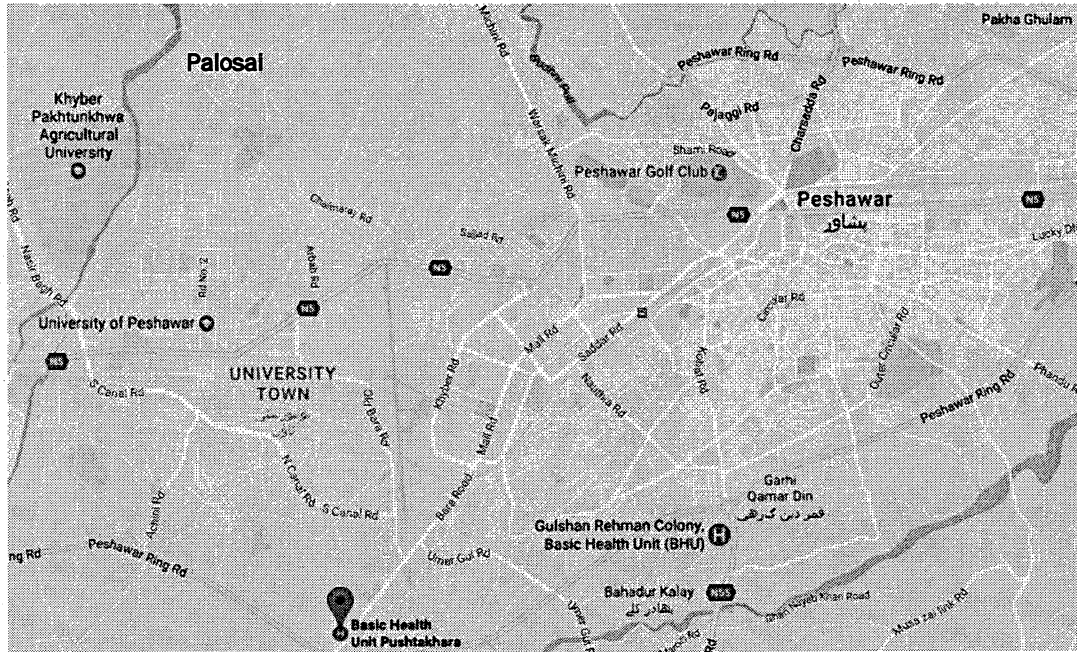
2. To analyze the communication difficulties encountered by the female patients with male doctors during routine medical consultation.

It is a well-documented fact that communication style differs between male and female gender (Roter, 2004). Female patients are found less vocal and conversant with male doctors. Whereas female physicians on the other hand, tend to devote more time, are more conversant and even try to use different communication approaches towards building a positive rapport with their patients during medical consultation. The objective of this study is to, therefore identify need for gender concordant doctors especially for female patients as it would have positive implication on the health status of the female patients.

3. To determine if culture barrier is more visible at lower socio-economic levels of the female patients.

The socio-political factors interwoven in the fabric of society reflect itself clearly in the healthcare system. The social class and gender interplay to render male doctors dominant position viz-a-viz females. This asymmetrical dyad is even more prominent when doctors are men and patients presented are women and

especially those coming from lower socio-economic backgrounds. This negatively affects the overall health care delivery.



Map 1: Basic Health Units visited in District Peshawar

## 1.5 Locale of the Study

### Overview of Peshawar District:

**History:** Peshawar, the capital city of Khyber Pakhtunkhwa province, previously known as NWFP. It is the strategic link between the subcontinent on one hand and Central Asia on the other serving as the center of trade between Afghanistan, South Asia, and Central Asian region and over to the Middle East for centuries. It is one of the oldest living cities of Asia, and been recorded in history as a thriving city of ancient Gandhara Kingdom having rich archaeological remains (KP .n.d.).

**Geography:** Peshawar is bordered by tribal agencies on its three sides covering its western boundary along the Afghan border. It is near the eastern end of Khyber Pass. The total area of Peshawar district is 1,257 square kilometre. It shares 1,100 kilometer border with Afghanistan. The city is a fertile plane watered by the Kabul river and Swat river. It

is flanked by Afghanistan to the north and the west, Azad Kashmir and the Northern Areas to the east and northeast, Punjab on the southeast and Baluchistan province on the south east.

**Culture:** Peshawar is one the most ancient cities with rich heritage and traditions. It has served as a host to the traders from South Asian region and Central Asian region. Culturally it is highly conservative and Islamic city with over 99% of the population being Muslims. Despite having overwhelmingly large population of Muslims, it had previously been home to some non-Muslim communities like Hindus, Sikhs, Afghan Jew, Zoroastrian, Baha'is and Christians (USAID, 2009) Pashtuns are known for their staunch tradition of hospitality and honour. "Let the head be gone, wealth be gone but the honour must not go, because the whole of dignity of a man is due to this honour" (Khattak, R.W.S., Mohammed, F., & Lee, R., 2012)

For the purpose of this study, primary level health centers – Basic Health Units BHU in the suburbs of Peshawar district were selected in the province of Khyber Pakhtunkhwa. The BHU is also called First Level Care Facility or FLCF. It is setup with the objective of maintaining primary health of the community i.e. to maintain family hygiene and healthy life of a family especially women and children. Each BHU visited had one male doctor (MBBS) present on duty, a Medical Assistant or Medical Technician MT (a lower cadre, non-MBBS staff) and an LHV or Lady Health Visitor, a mandatory post at all facilities, who checks the female patients and resolves their general and minor female health issues like flu, fever, respiratory problems and also their reproductive health.

The health centers at the secondary and tertiary levels like Satellite Hospital on Kohat Road and Government Teaching Hospitals - LRH were not included in the study because female patients visit these hospitals on choice to get treated by female physicians. The Teaching Hospitals are equipped with modern state-of-the-art technology and highly experienced staff for providing better health services almost free of cost to general public. These hospitals are equipped and designed to handle large-scale national or provincial level emergencies e.g. earthquake devastation, dengue epidemic, terrorist attack or bomb blast victims are all treated here. Patients with serious health complain are also treated in these hospitals. There are a considerable number of lady doctors available in all major

departments like gynaecological, paediatrics, surgery, medicine, radiology, ophthalmology etc. Since the objective of my study is to analyze the interaction between female patients versus male physicians, these hospitals were not chosen as they already provided ample choice and options to female patients to consult female doctors. Hence it did not provide any opportunity to address the research question.

### **1.6 Significance of the Study**

The research work that is undertaken here, analyses the interaction between female patients and gender-discordant physician. It is an innovative study in the sense that it combines together discourses at national and international level on patient-physician gender differential behaviour on one hand and a field study on female patients' interaction with male doctors on the other, narrowing it down to culture as the main impediment. There has been a considerable amount of work done on doctor-patient consultation and the importance of culture in medical care. However, the existing literature overlooks the influence of culture on medical consultation between female patients and male doctor gender. The study of this kind gains more importance taking in view the traditional societal setup of our country and our rural areas. The work aims to highlight the prevailing cultural norms in our society which discourages women to consult male doctors in the absence of female physicians. I am particularly keen and interested in sharing the findings of this research with the government of Khyber Pakhtunkhwa and relevant Federal agencies. It is an endeavour to reveal the facts and on-ground realities in the health care facilities and provide valuable information which could contribute towards the improvement of the health services for female patients and provide them with better control over their health, resources and lives.

## A CONCEPTUAL FRAMEWORK

### INTERACTION BETWEEN MALE DOCTORS & FEMALE PATIENTS WITH CULTURE AS A BARRIER IN ACCESS TO HEALTH CARE

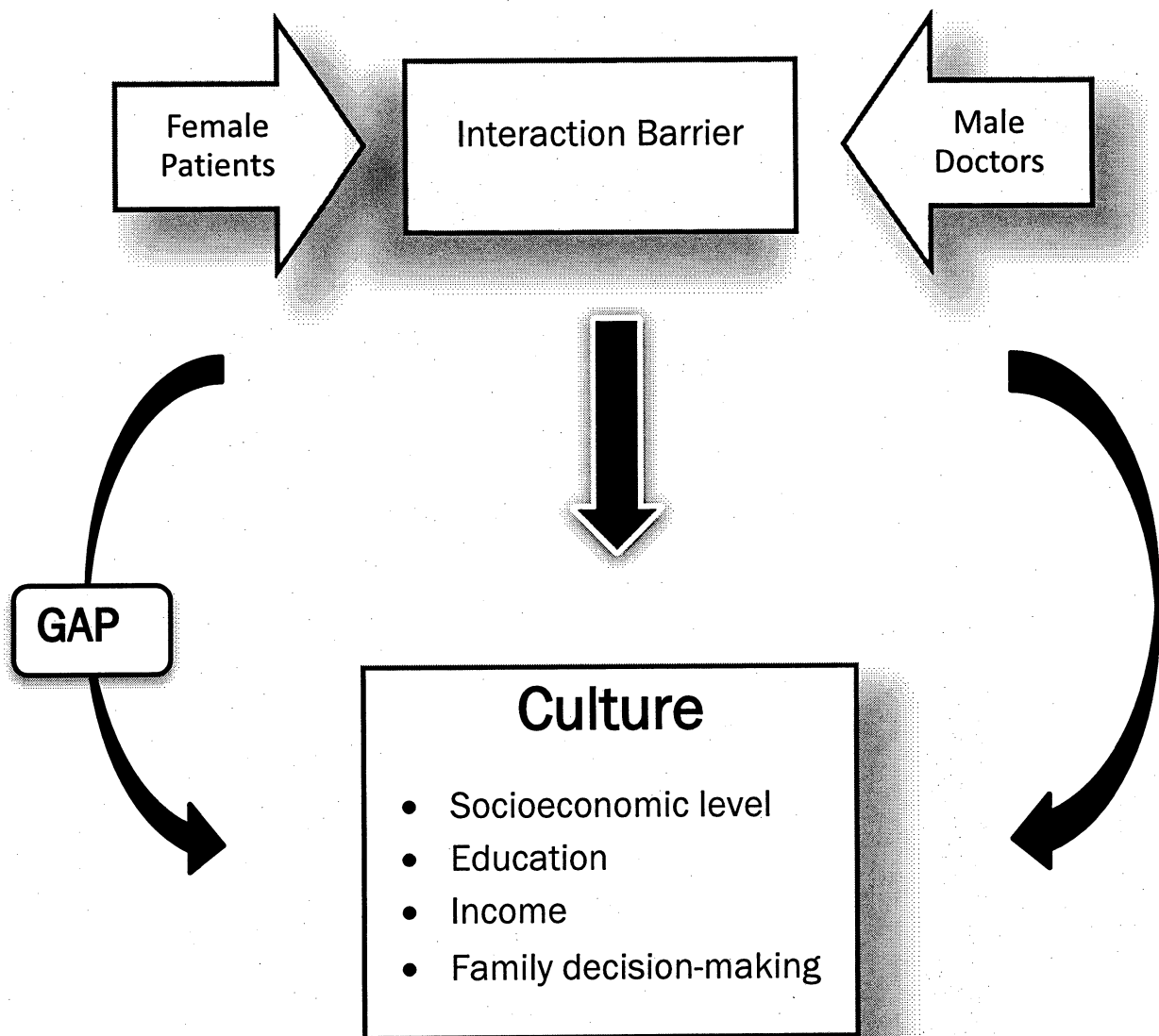


Figure 1: A Conceptual Framework - Interaction between Male Doctors & Female Patients with Culture as a Barrier in Access to Health Care

### **1.7 Conceptual Framework**

The research work is explained through the conceptual framework in the above diagram. The study sheds light on the medical interaction between two main protagonists: female patient and male doctor. The interaction in medical communication between patient and physician involves direct conversation of native language and nonverbal communication-body language, emotional cues etc. In medical conversation, a female patient feels more comfortable interacting with female doctors than male. Female patients are at greater ease sharing their personal health problem with female physician. While the male doctors, in the given male dominated society use the tool of language and their knowledge to overpower the female patients, through use of communication skills, certain non-verbal gestures, body language, pressure tactics during medical communication. Communication style varies with gender change. Where female style of communication embraces empathy, compassion, gentleness and generally more talk, male style of communication involves more assertiveness and less talking.

This research delves further into the topic of interaction between male and female in the field of medicine, which has already been expanded by many forerunners in the field like (Henley, 1979; Homans, 1980; Gray, 1982; & Roter, 2004). Among various problems encountered during the medical interaction between female patients and male physician, culture is taken as the main barrier (Ali, Bhatti, & Kuroiwa, 2008; Miller & Arquilla, 2007) for the purpose of this research. Culture plays a significant role in the health seeking behaviour of individual. How illness is conceptualized and treatment is sought by an individual are influenced by cultural factors (Fisher & Groce, 1985). Moreover, cultural manifests itself in varying dimensions like socioeconomic level, education, income and family decision making etc. all of which combine together to impact consultation between male and female members. With lower socioeconomic level, cultural divide between male physician and female patient is more prominent than at higher levels of socioeconomic levels (Waitzkin & Waterman, 1974; Ehrenreich & Ehrenreich, 1970; Strong, 1979; Navarro, 1976; Wallen et al., 1979).

The gap presented in the diagram is the status-quo situation in health facilities where female patients due to the traditional societal setup especially in the rural areas are culturally inhibited to interact and share their health issues with the male doctors (Asad et al, 2012; Mahmood et al, 2002). Whereas the non-availability of female doctors in primary care centers make it harder for female patients to get easy access to health care.

### **1.8 Limitations of the Study**

For the purpose of this study three BHUs were selected and visited in the suburbs of Peshawar district. The first limitation was to include only the first-line-care-facility (FLCF) in the study. This conscious decision was based on the assumption that if female patients feel inhibited or reluctant to consult a male doctor at primary level facility for primary nature illness then it is unlikely to work otherwise for female patients to consult male doctors at higher level of health care for serious illnesses.

Although considerable amount of data was collected from these three facilities, however, the number is still small to generalize the finding to the rest of the BHUs in the whole region or other provinces. The extent of cultural barriers faced by all female patients could be ascertained well through a comprehensive study of bigger sample in different provinces.

At each BHU one male doctor present on duty was interviewed. Due to the nature and scope of the study female doctor were not interviewed. The data collected from female doctors could have supplemented and added another perspective to the study.

From each BHU, initially the number of female patients considered for interview was taken as ten. However, the number had to be reduced as after interviewing more than five female patients in the same BHU, the saturation point was reached, whereby similar kind of responses were being received with no new opinion or point added.

Due to the time constraints and cost, BHUs near the area of the researcher's home town were explored. Other facilities further away were not visited which could have made the

data more varied. This kind of study approach is desirable in situations where resource and time limits do not permit population surveys.

However, since the female patients visiting these BHUs and the medical staff- LHVs and MTs come from far flung areas and their opinions and insights were also collected and added, we could get a generalized data which could be approximated to other areas of Peshawar district.

## CHAPTER 2

### Literature Review

#### 2.1 Introduction

Numerous studies around the world have been undertaken in the field of health and medical research which brings to light the medical interactions between doctor and patients with special reference to gender discordancy, effects on consultation process, communication and subsequent effects on health care delivery. One such extensive study had been covered by the Netherlands Institute for Primary Health Dutch Health and Welfare Ministry (Bensing, 1993). According to the study, the classical dyad in any medical encounter would consist of a male physician and a female patient (Groenewegen, et al. 1992). About 60% of the patients that arrive at the Dutch primary health care centers according to the research are women. This happens to be a universal phenomenon in the rest of the world as well (Cooke, 1985 & Preston-Whyte, Fraser & Beckett, 1983). On the other hand, the ratio of male-female GP working shows a contrasting picture. About 87% of Dutch GPs are male whereas the remaining are women. Hence, there is an urgent need for more female physicians to enter the field so as to enable patients to choose between a male and female doctor. Women generally prefer a female physician and some health issues are better and easily presented to a female doctor than male. Similarly, the care provided by the female physician is also better. Going by patients' preferences, most patients prefer to have a physician of the same gender. Female patients especially favour a female doctor for female-specific health issues (Haar 1975), (Fennema, Meyer & Owen, 1990), (Nichols, 1987), for problems that are of intimate nature or embarrassing to discuss and for behavioural problems. (Fennema, Meyer & Owen, 1990), (Ackerman-Ross, Sochat, 1980), (Zare, Sorenson & Heeren, 1984).

Bensing (1993) makes a reference in his study to an American research which points out towards female physicians, spending more time with their patients especially the females (Roter, Lipkin & Korsgaard, 1991). Moreover they also tend to have a favourable and

congenial attitude towards the psycho-social factors in patient care and counselling (Maheux, et al. 1990).

An extremely interesting point raised by Bensing (1993) in the article is the different morbidity patterns represented by female and male physicians. Female health issues like reproductive, gynaecological and family planning etc. are over represented with female doctors whereas male specific problems like male genital issues, muscular-skeletal and respiratory problems are common with male doctors. A doctor's gender is very important in general practice. The general physician GP not only attracts patients of same gender but also specific types of health problems regardless of the patients' gender. It is noted that health complaints correspond to certain pre-existing notions or gender-biases that masculine health problems – male genital system and muscular-skeletal problem due to injuries, accidents and respiratory cases are most common in male doctor's room. Whereas female health related issues along with social and metabolic problems are more represented with female doctors (Bensing, J; Brink-Muinen, A; Bakker, D. 1993).

Another very important study had been undertaken in the US on the Muslim female patients in the US interacting with American doctors (Hasnain, 2011). According to the study regardless of the country of their origin, all Muslims irrespective of their with diverse cultural and ethnic identities, share a strong bond of religion that guides their social, public and private lives, influencing their health beliefs and practices including reproductive, maternal and child health and sexual-norms. (Lawrence, et al. 2001). Muslim women's health issues have specific religious and cultural needs which cannot be ignored. For instance, the need for same-gender health provider, personal hygiene issues for daily prayers, special needs during fasting etc. need accommodation and thorough consideration by the health care takers. Hasnain (2011) cautions that insensitivity towards such cases could lead to female patients avoiding health care facilities until the advance stages of illness, risking further deterioration in health and resources. The study propagates for religious and culture specific needs of the patients which require modesty and family involvement health decisions. The author points out that it would be sheer insensitivity on part of the health provider to not provide Muslim women a female physician for consulting health problems and performing physical examination of

intimate nature; such as breast and pelvic examinations. These examinations performed by a male doctor are a standard in the West but would be a cruel violation of trust and confidence and modesty needs of Muslim female patient and her family. It would cause personal disgrace, indignation and resentment between the patient and the health care providers (Hasnain, M. 2011).

Gender differences in communication, in clinical settings among physicians from primary care and specialists had been well documented (Hall, Irish, Roter, Ehrlich, & Muller, 1994a). There has been a lot of research done on gender differences in patient-doctor communication in the Western world. However, research has not been carried out so extensively and intensively in the developing part of the world especially South Asia where interaction between male and female is found more challenging (Uskul & Ahmad, 2003). One such study was conducted in the gynaecology clinic at a state hospital in Istanbul, Turkey 'Physician-patient interaction: A gynaecology clinic in Turkey' with the objective to observe the male and female gynaecologists' communication with their female patients. According to the study majority of the female patients visiting the state hospital were Muslims and came from socioeconomically deprived and faced varying behaviour from the male doctors (Uskul, A. K., & Ahmad, F. 2003).

Gynaecology is related to a woman's sexual health and includes interaction between a female patient with an unknown female or male doctor. Uskul & Ahmad (2003) in their study underlines that it is paramount to understand the religious and cultural context which gives a woman her distinct role and status. Turkey is like any other Muslim or Asian country where difference in men and women and their socio-economic segments are distinctively observed. The prevailing gender segregation and female seclusion puts a limit on women's access to public areas as an established social norm. The women's bodies and sexuality are kept under control not only in the familial sphere, but also by the Turkish state discourse (Sirman, 1989). The Turkish family is patriarchal which gives importance to the male members of the society. In rural parts of the country, females only interact with males from their family or relation. Woman's purity and dignity are closely intertwined with her family's honour. To safeguard the family honour, women's lives are often regulated by the male members of the family (Sev'er & Yurdakul, 2001)

Uskul & Ahmed (2003) observes that male physicians treated women from different educational, socioeconomic and religious backgrounds in different ways. Female patient who appeared more religious and from low socioeconomic backgrounds were treated rudely and snubbed by the male doctors as compared to patients who were liberal, educated and from higher socioeconomic level and did not resist getting checked by the male doctor. The study underlines that the goal of a clinical examination is to reach a correct diagnosis and carry out an optimal treatment programme. This objective is more likely to be realized in a female dyad of gynaecologist-patient relation because of the greater amount of information shared by the patient (Uskul, A. K., & Ahmad, F. 2003).

According to the World Economic Forum's (WEF) Global Gender Gap (GGG) Report 2016, Pakistan ranks at 143 out of total 144 countries in the Gender Inequality Index, far below its neighbours Bangladesh and India which ranked at 72nd and 87th respectively. Disappointingly enough Pakistan also happens to be the worst performing state in South Asian region in this regard and remains so for the last couple of years. The only country ranked below Pakistan is Yemen at 144, while Syria is one place ahead at 142. The GGG report checks progress towards parity between men and women in four areas: educational attainment, health and survival, economic opportunity and political empowerment (Khan, 2016). Pakistan also lags behind many of the developing nations in mother-child mortality and health.

According to another report Pakistan's ranking in the 'Mother Mortality Ratio (MMR)' had slipped from 147th last year to 149. Moreover, except Afghanistan, all the countries in the region have much better health indicators than Pakistan. Pakistan has sustained a high MMR of 276 per 100,000 live births and the under-five child mortality rate of around 89 deaths per 1,000 live births during the last a decade or so. One in every 170 women in Pakistan has the lifetime risk of maternal death. The report also added that babies living in crowded and unhygienic slums lacked access to basic facilities such as safe drinking water, immunization, mother and baby care during pregnancy and immediately after delivery, treatment for diarrhoea, pneumonia and other common illnesses (Junaidi, I. 2015)

One reason for this detrimental picture is the culture of the country which prohibits women folk to think in her welfare. The system is devastated by non-availability of women's health needs which are reflected not only in the low quality of services but also by the poor health indicators (ibid).

Asad, et al. (2012) in their article 'Women Health Issues in Khyber Pakhtunkhwa Pakistan: A Third World Experience' observe that a weak socio-economic status of women coupled with the existing cultural barriers are the major causes for poor women's health. From the stand point view of socio-cultural facet of Pakistani society, women are given inferior position as compared to men, they have no right over their sexuality, less mobile as compared to men and in case of distribution of food it is also more skewed towards men and male members of the family than women which leads to the latter's malnourishment and overall poor health status. (Asad, et al. 2012).

In another study conducted by Alam & Khan (2008), problems and challenges faced by the rural women of Peshawar in their pre- and post-natal conditions are brought to the fore. The study points towards the dismal state of female's status of poverty, ill health, low social status and reproductive role put them in high risk of health, needless suffering causing many deaths and terminal disabilities that could have been prevented (NIPS, 2001). Moreover, women are prone to suffer from deficiency in micro-nutrients since childhood which become more severe over time causing problems of anaemia, iodine leading to high mortality in mother and baby or serious abnormalities. It is strongly debated that the poor and miserable health status of female gender is as much a social problem as a medical. Factors that are attributable to this situation includes lack of awareness on behalf of women and lack of attention to women's health requirements, low education coupled with weak social status and social constraints including mobility of women and girls and the practice of seclusion. All these factors have snowball effect on the poor health and quality of life for women (UNICEF, 1997).

An important study carried out in the Sindh province (Mahmood, et al. 2002) identifies the major health problems and reproductive problems for which people consult their doctors. The findings in this study bear quite close approximation to the objectives of the underlying research work. According to the Sindh study carried out in two main districts

of Khairpur and Naushero Feroz, most of the medical practitioners in the area were men. Whereas females generally preferred to consult same gender physician or health care provider. Also female patients consulted both female and male doctors for various general and female specific health issues like menstrual disorder and reproductive issues. This tendency among female patients reveals lack of female physicians, the respect practitioners command and higher morbidity among women. However, more important is to note the point that due to prevailing cultural norms, women do not receive necessary health care for their reproductive issues. Authors of the study mention low access to food and high parity as the major contributing reasons for high incidence of anaemia (Bhurt & Fikree, 1999). The same study also revealed better communication and consultation process by female physicians which was the main reason for high patient satisfaction with them (Bertakis, et al. 1995). This led to greater sharing of information between the patient and female medical practitioner and thereby identifying the underlying, deeper social issues contributing to illness (Mahmood, M. et al. 2002).

## 2.2 Culture

The concept of culture is not of recent times. From Bible to Homer, Hippocrates, Herodotus and to Chinese scholars of the Han dynasty, individuals have pondered all along over the distinctive ways of living of different people (Kroeber & Kluckhohn, 1952).

In the Consolations of Philosophy written in sixth century AD, Boethius alludes to the principle of cultural relativity. In his words: "The customs and laws of diverse nations do so much differ that the same thing which some commend as laudable, others condemn as deserving punishment". (Kroeber & Kluckhohn, 1952, p. 3)

Kroeber and Kluckhohn (1952) present Descartes's (1637) idea of culture in a more refined manner, taken from the latter's work Discourse on Method:

*While traveling, having realized that all those who have attitudes very different from our own are not for that reason barbarians or*

*savages but are as rational or more so than ourselves, and having considered how greatly the self-same person with the self-same mind who had grown up from infancy among the French or Germans would become different from what he would have been if he had always lived among the Chinese or the cannibals . . . I found myself forced to try myself to see things from their point of view*

By the nineteenth century, the basic notion of Culture was crystallized in a clear and generalized form. The word culture with its modern anthropological meaning was first shaped by E.B. Tylor in 1871. The word was borrowed from German language word 'Kultur', where it had evolved from its original meaning of 'cultivation'.

Taking definitions of Culture from more recent times:

A relatively simple and concise definition of culture given by the British anthropologist E.B.Tylor (1870), cited by Avruch (1998: 6) and taken from the works of Spencer-Oatey (2012):

"Culture is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (quoted in Spencer-Oatey, 2012, p. 2).

It is a complex whole that involves shared traditions, customs, language and norms that are learned and acquired from families and social communities over generations (Spector, R.E. 1991)

For analyzing the patterns in which health services are utilized, understanding the concept of "culture," - a patterned way of life that has special meaning to the individual and his or her social group - is imperative. It predisposes whether the individual would utilize the health care services or refrain from it.

Culture affects behaviour and interpretations of behaviour: Spencer (2008) makes a relevant and important point as to culture being able to influence behaviour of individuals and their interpretations. The reference is made to Hofstade (1991) and is closely

associated with my study as well. Hofstade (1991) observes that certain aspects of culture may physically be visible but their meaning is invisible or implicit. Hence, their cultural meaning clearly lies in the ways these practices are interpreted. For instance, making a sign of 'ring gesture' with thumb and forefinger touching carries a positive connotation of approval and acceptance in the West, but could be taken as an obscene or a rude gesture in certain Mediterranean countries (Spencer, 2008). Similarly, one's choice of clothing and dressing up also carry different connotation and interpretation in different regions (ibid). For instance, shorts worn by men in the western countries is a normal sight especially in summers yet accepted with some reservation in some Muslim and Pashtun culture.

### **2.3 Communication**

Communication is a process of sharing information with the purpose of creating mutual understanding. In other words, it is an act of conveying a message through the exchange of ideas, in form of speech, writing, and illustrations or by behaviour (Velentzas, & Broni, 2014)

Communication is also defined as a 'meaningful exchange of information between two or more people' (ibid). Communication could be initiated intentionally or unintentionally, could involve linguistic or non-linguistic form and could take place through spoken or other modes (Mehrabian, 1972).

Communication as mentioned earlier could be verbal or non-verbal communication. The word communication is derived from the Latin word meaning "common" (Velentzas, Mamalis & Broni, 2010). To communicate, thereby means to make common, make known or to share mutually some information – written or visual form such as body language.

When two people communicate, the message that is received, perceived and interpreted depends upon each person's cultural conditioning and his/her cognitive judgment. Communication can be divided into three categories: verbal which include speech and words with specific meanings, para-verbal that includes the tone and non-verbal

communication which include sign language and body language (Ferraro, 1990). Language, used in verbal communication is deeply ingrained in the particular culture of the speaker and does not carry single universal meaning (Hargie & Dickson, 2004). Similarly, it is not possible to understand a culture without its language and similarly vice versa. Language plays an important role in creating the context of negotiation and in allowing negotiators to prepare for cross-cultural interactions (Rubinstein, A. 1999).

Nonverbal communication implies emotions, attitudes and feelings show in different gestures and motions (Hargie & Dickson, 2004) and it may be conveyed unintentionally by facial expressions, gestures, and body language. An understanding of non-verbal communication is said to be one of the most important parts of communication between people from two different cultures (Usunier, 1996). Non-verbal signs assist the interpretation of verbal messages and they may have greater significance than the verbal aspects (Hargie, O & Dickson, D. 2004).

#### **2.4 Socio-Cultural Factors and Health Seeking Behaviour**

As discussed earlier, healthcare service accessibility depends a lot on socio-cultural factors. It requires understanding the culture of individuals utilizing the health services. Understanding culture in health care situation is of utmost importance as it predisposes the individual to either utilize given health service or refrain from it, remaining in her or his cultural norms (Ali, M. 2008).

One's culture is a system of shared beliefs, values, customs, behaviour and artefacts that members of society use in coping with one another and their world. These shared beliefs and values are transferred over generations through learning (Leininger, 1970) and (Bailey, 1987). Medical anthropologists pay special attention to the meanings that people ascribe to illness and relation between meanings and their behaviour.

## **2.5 Cultural Barriers for Female Patients in Health Care**

Cultural norms dictate that women should be examined by women doctors only, while the latter's dearth make the service delivery inaccessible (Ali, Bhatti, & Kuroiwa, 2008). The physical accessibility of a primary health service is determined in terms of number of population living within 2 to 5 km radius area. Whereas, social accessibility is taken in terms of religious, tribal and cultural barriers in accessing the services. In Pakistani society it is observed that female healthcare providers are essential and required for all reproductive, gynaecological antenatal, natal and postnatal care (Kielmann, A., et al. 2002).

The inability of women to travel alone to the healthcare center as and when they desire is considered an important barrier in improving their health status (Cleland, et al. 1996). The majority of women reported are required to visit the health facilities only when accompanied with the male members of the family (Mumtaz & Salway, 2005) & (Piet-Pelon et al. 2000). Moreover, in a traditional and conservative society like Pakistan, female patients would clearly feel uncomfortable or shy away from discussing health issues regarding female problems especially reproductive issues with male doctors. Needless to state, the female patients would clearly request for female doctors for their gynaecological and even general health issues (Green, et al. 1997), (Winkvist & Akhtar, Z. 1997) & (Khan, A.1999).

The dearth of female physicians makes (physically) accessible health facilities socially inaccessible and unacceptable. Thus, depriving women and the bearer of future generation of their basic right to equality of medical treatment and dignity (Ali, M; Bhatti, M.A & Kuroiwa, C. 2008).

Miller & Arquilla (2007) in 'Disasters, Women's Health, and Conservative Society' have articulately combined together the multiple cultural barriers faced by the women in South Asian region, especially Pakistan, in a nutshell. According to the report, the physicians in a culturally conservative society like that of Pakistan must understand that for a woman especially from rural areas to speak to a male physician about their health issues could be an incredibly embarrassing experience. It becomes even more awkward and gauche for the patient when the issue is of gynaecological order, urinary, abdominal, breast complain

or any other issue that would require areas of the body to be exposed during the examination which are normally covered. Such cultural barriers prove insurmountable and overwhelming to most women, thus inhibiting them from getting necessary and timely health care. Healthcare delayed could be health care denied. This regressive condition could be improved by employing women healthcare workers, physicians and nurses and even translators to assist women patients where required. Miller and Arquilla (2007) rightly underlines the fact that within any given population several cultural barriers may exist that inhibit or impede females from utilizing available benefits of healthcare services (Miller, A.C. & Arquilla, B. 2007).

## **2.6 Gender Difference in Doctors and it's Effects on Patients**

On the effect of doctor's gender on the doctor-patient relationship, Judith Gray (1982) relates a basic observation that with male doctors, female patients tend to be less vocal and verbal than their counterpart - male patients, but when the doctor is female, female patients tend to communicate more information during medical consultation. More so, it is observed that male and female patients tend to talk easily with female doctors than male (Sawyer, 1979). Earlier studies in the field of doctor-patient relation have focused on gender differences from the view point of patient gender, whereas the doctor is taken as a professional only – neither male nor female (Gray, 1982) It is exceedingly important to know, however, whether the relationship between gender concordant female physicians and patient is any different from that of gender-discordant male physician and female patient.

A woman by nature is considered a tender being and is socialized to be gentle, caring, emotional, nurturing life and family (Walton, 1968) (Cartwright, 1967). Women medical students are also observed to be patient-centred, sensitive towards relationship values and take greater interest in someone's emotional suffering (ibid). People mostly choose their physician depending on their physical or geographic accessibility but female patients essentially prefer to visit female physicians (Walton, 1968) (Cartwright, 1967) and certain factors necessitate this requirement.

Henley, (1979) and Homans, (1980) while discussing patient preferences underscore certain factors that predispose women to prefer female doctors. For instance, most Asian women prefer women to men doctors especially in gynaecological problems and care. Haar, et al. (1975) found in a study that female patients favoured female physicians and gynaecologists, because they believed their physician to be gentler, spent more time and tried to make them feel comfortable and at ease. More importantly, it was observed that women patient felt inclined towards female doctors because by sharing same physiology, female doctors are believed to genuinely understand women's condition and how it feels whereas male doctors are found to be at natural disadvantage here.

### **2.7 Gender Difference and Doctor – Patients' Communication**

Gender differences lead to variation in communication style (Roter, 2004). In numerous studies undertaken on physician-side communication only, the impact of patient side communication, in shaping doctor-patient relationship has been overlooked. These studies have essentially ignored the issue of how patients would interact with different gender doctors male versus female. This topic becomes essentially important when considering all the discourses on gender influenced variations in communication styles of male and females and their effects on the conversing party. Roter (2004) rightly puts forth the issue of patient-centred communication, rather than physician-centeredness in order to better assess the mutual dynamics of both the patient and physician in medical interaction (Roter DL., 2004).

Similarly in the study 'Sex Differences in Patients' and Physicians' Communication During Primary Care Medical Visits', Roter (1991) has explained at length that physician gender differences effects the duration of, structure and even the matter discussed in medical interactions. This difference has significant implications on the communication process between the patient and doctor during medical visit. Female physicians, as observed earlier are found to not only engage in significantly more talk during the medical visit, but so do their patients. Studies undertaken on doctor-patient communication during medical visit yield several pertinent conclusions. Female physicians conduct medical visits differently from male physicians: they devote more

time on average to each visit with the patient especially the female patients, female physicians are more conversant with their patients and they use different communication strategies that are patient-centred and conducive towards rapport building and positive communication. More compelling is the fact that these communication differences are more prominent during the history taking section. Similarly, patients are found to talk more with the female physician and appear to participate more willingly during medical dialogue. Patients tend to ask more questions, engage the physician more with their concerns and are likely to yield more information – biomedical as well as psychosocial when the physician is a woman. Last, and most important conclusion revealed through various studies is that female patients benefit more from exchanges with female physicians through longer and more participative medical visits. Studies suggest that recognition of gender concordance in patient-physician for females has positive implications in form of increased sensitivity and better interviewing skills which could benefit all doctors (Roter, et al. 1991).

## **2.8 Doctor-Patient Negotiation of Cultural Assumption**

Cultural assumptions about women take on increased significance when considered in the context of the structure of the medical relationship.

Fisher & Groce (1985) in their study on 'Doctor-patient negotiation on cultural assumption' notes that throughout the time, how individuals behave in certain ways in particular situations has remained a topic of great interest and deliberations. The explanations in turn generated have linked norms or rules for behaviour with action. Physicians are integral players in health care system. As cultural members of the society and medical institutions they share pertinent set social and medical information about women as part of their professional knowledge. Waitzkin and Waterman (1974) on the other hand points to the fact that patients mostly lack the medical knowledge to assume equal position in medical encounters. Moreover, this inadequacy of knowledge, at lower income levels and education is wider at lower socioeconomic level. Hence, patients coming from lower socioeconomic background having less knowledge and fewer choices in the medical setting they visit, are also perceived as less responsible and vague

(Ehrenreich & Ehrenreich 1970). Further adding to this, Waitzkin and Waterman (1974) reveals an interesting fact, that such patients when seek medical help, take a subordinate position viz-a viz the physician who readily assumes the superior position.

The role of women also contributes to being powerless in many social interactions. A study by Ehrenreich and Ehrenreich (1970) points out that women are generally perceived to be difficult, erratic and emotional beings and unable to comprehend complex details by doctors. This clearly renders female patients in weak and hapless condition. The asymmetry in patient-physician dyad is strongly acknowledged by social scientists, health care providers and health seeks alike. Moreover, the doctor-patient interaction is also studied from the view point of how it shapes the medical dialogue and subsequent health care delivery. Strong (1979) in this regard made a remarkable note of the medical interaction being responsive to a variety of socioeconomic factors: underlying medical problem, social class of the patient and the venue or setting of the organization. In doctor-patient communication, patient prompted questions are disapproved (Frankel, 1990). This prejudice is heightened when doctors turn out to be male and patients female. In our society, the roles of men-women and doctor-patient relation reinforce each other. Male doctor and female patient are locked in an asymmetrical relation in which female patient is dependent on the male physician's judgment – by the virtue of his having higher knowledge and medical information– about them as woman. These judgments are most often abstracted and generalized from the daily lives of the women and reinforced by the traditional assumptions about the appropriate roles for women in our society (Fisher, S. & Groce, S. B; 1985).

An important study of its kind is undertaken by Fisher & Groce (1985) which explores the cultural assumptions or norms about female patients as they form the medical interaction between the physician and the patient and the consequences it has for the health care delivery. It is pointed out that cultural assumptions or norms about women take greater significance in the context of medical interaction. These medical interactions between the doctor and patient are essentially social and micro political. Navarro (1976) claims that the social and political factors woven in the fabric of society are reflected in health care system where the social class and gender interplay to provide male-gender

physicians a dominant position in medical hierarchy. The medical interaction between physician-patient is caused by cultural, structural and institutional factors. Medical communication reflects power differentials in a society dominated by particular class and gender and medical profession essentially mirrors this dominance (Wallen et al., 1979) (Navarro, 1976). Doctors, by virtue of their profession, have knowledge and expertise that patients lack, it is therefore, not too surprising that the patients generally accept the subordinate position without question. When doctors are men and patients are women, this imbalance is further heightened. This asymmetry and paternalism which describes doctor-patient discourse in the form of institutional authority of the practitioner's role, affects health care delivery (Fisher, S. & Groce, S. B. 1985).

## **2.9 Cultural Aspects of Health & Illness**

For a medical treatment to be successful, cooperation and compliance of the patient and the family is of utmost importance. For this, we need to understand the concept of culture prevailing in the society. Medical professionals are required to increase their awareness about the cultural attitudes ascribed to health issues and adapt their treatment plan in accordance (Hartog, J. & Hartog, E. A. 1983).

Patient behaviour regulates the extent to which a patient gets involved in his own treatment - taking or not taking part in decision making is influenced greatly by the patients' degree of dependence or independence. Culture along with gender roles play differential effect: for instance men are found to be more independent in their decision making process yet often needing to be taken care of than women. Elderly men are found to be more complaint because they need to be taken care of. More independent patients may prove hazardous to themselves by shielding their own illness. While too much of a reliant and needy patient might be testing and cause rejection (ibid.)

Illness behaviour shows how an individual behaves as a patient and this peculiar behaviour is significantly determined by the culture (Hartog & Hartog, 1983). The illness process begins when the person become aware of some altered body feeling and this state continues as the sufferer is regarded as ill by the family or by himself. Treatment is

sought personally or with support of the family. Advice is taken, even from extended family members and community and professional and marginal practitioners in health are also consulted (Kleinman, A., Eisenberg, L. & Good, B. 1978).

Compliance, cooperation, resistance and despair all reflect cultural attitudes in healthcare. The family's attitude towards illness is also influenced by the cultural values. For instance, a rural peasant family may be more attentive towards their ailing family member than the urban family who delegates the care to the medical personnel. The rural family has designated roles and behaviour towards the sick and disabled, shaped over generations through traditions and values (Hartog, J. & Hartog, E. A. 1983).

The decision about patient's treatment is highly influenced by culture too. From medical and professional point of view, the doctors along with patient's consent make the decision. Whereas, from patient's family side, depending on the culture, there are authority figures who may elicit more assertiveness than the physician (ibid).

Communication – Verbal & Non-verbal: a general behaviour showing polite mannerism, modesty, spatial distance and cautiousness in touching convey significant nonverbal messages between patient and physician which if ignored or violated could damage the rapport and thereby disrupting the treatment (Hartog & Hartog, 1983). Unwanted or excessive touching of body could convey odd meaning about the practitioner doctor and care must be taken overdo this and upset the patient or the family. Especially among Muslim, major problems arise during the examination of private body parts by the opposite gender especially the parts covered with clothes.

Different cultures dictate different spatial distance between two people and ignorance of which can create serious misgivings. Addressing female patients with endearing words like 'honey', 'dear' or '*jan*', '*soni*' may call for unwarranted intimacy and create an unpleasant situation. Most Asian or non-Western cultures give a lot of care to manners and respect observed in different situations due to the established rules of conduct for every interaction. (Hartog, J & Hartog, E. 1983).

## **2.10 Health Seeking Behaviour in Pakistan: Private Providers and traditional healers in healthcare system**

In Pakistan, the use of public health facilities is lower in rural areas as compared to urban areas (Anwer, Green, & Norris, 2012). Contributing factors cited for not using the government healthcare facilities in rural areas are inability to access health facility on time due to distance which is further aggravated by poor transport system, restricted hours, non-availability of required paramedic staff and doctors, dearth of female doctors, lack of drugs and inferior care quality coupled with low literacy rates in rural areas and lack of health education which keep people away from using public services although they are provided at subsidized rates by the government (Anwer, Green, & Norris., 2012). The reasons for utilizing private health facilities in developing countries cited by users include better and easy accessibility, short waiting time, better confidentiality and sensitivity towards patients (ibid). Although quality of health services provided by many private facilities is found inadequate and substandard.

Use of complementary and traditional medicine have seen a positive, increasing trend in many of the developing and developed countries in the past few decades (Anwer, Green, & Norris, 2012). Traditional medicine as defined by WHO is “a sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as prevention, diagnosis, improvement or treatment of physical and mental illness” (WHO, 2008).

In Pakistan, the informal healthcare sector comprises of traditional healers also known as Hakeem in local language and homeopaths, spiritual and faith healers, bonesetters, traditional birth attendants – Dai in local language and quacks. According to The Punjab Health Commission Regulation on Banning Quacks, Draft (2016), a quack is defined as any “pretender providing health services without having registration of the Pakistan Medical & Dental Council, Council for Tib, Council for Homeopathy or the Pakistan Nursing Council” (The Punjab Healthcare Commission Regulation for banning quackery,

2016). It includes all practices and methods which are unsubstantiated and not backed by scientific rationale performed by any person who is not authorized to perform it as per government laws.

In the field of medical pluralism where formal and informal health sectors operate side-by-side, 'healer shopping' is a common practice. People generally tend to change healers more readily as they want quick fixes (Anwer, Green, & Norris., 2012). Some of the common reasons for preferring informal health care service over the formal sector cited in research are low or poor socio-economic status, strong belief system, easier access and lower cost (ibid).

### **2.11 Gender Relations in Pakistan and among the Pashtuns**

Sanauddin (2005) refers to Pakistan as a region lying in the 'belt of patriarchy' i.e. having a culture which goes against women (Moghadam, 1992, p.107). He further notes that social status of women is not homogenous across all regions; infact there is considerable variation in the status of women along different classes and along rural-urban divide. A woman's reality, therefore depends on her association to a certain class i.e. whether she is from a highly educated family background, part of a middle class urban family or living in a tribal area where customs have remained unchanged and unaffected for the time unknown. (Sanauddin, N., 2005). Pathans are considered more rigid and conservative as compared to other ethnicities in Pakistan, with regards to gender role and women's purdah i.e. seclusion of women folk (ibid).

Pakistan is predominantly a rural country , with approximately 64% of the population residing in rural areas as compared to only 36% in the urban according to the latest population census report of 2017 (Population Census, 2017). Pakistan is rich and diverse ethnically and linguistically. The four major provinces in Pakistan are home to the four major ethnic and linguistic groups living in Pakistan i.e. the Punjabis live in Punjab, the Sindhis inhabit Sindh, the Baluchis in Baluchistan, and the Pashtuns mostly live in Khyber Pakhtunkhwa (Sanauddin, 2005). About 96.3% of the 20.7 million population is Muslim; while the remaining population is divided among Christians, Hindus, and other

sects spread across all the country (Census, 2017). The Pashtuns are an ethnic group of more than 35 million (ibid) people spread across the provinces KPK and Baluchistan and FATA.

While describing the family structure in Pakistan, Sanauddin (2005) observes that with more people living in a joint family system, the role of family further perpetuates the system of patriarchy in our society. There is a strict and clear division between the roles of male and females and rules of gender, requiring women to remain inside the house. With reference to KP, Sanauddin (2005) mentions that in a Pathan family generally, the father or another older male such as grandfather, uncle or brother leads the household in all social relations and make all important family decisions: arrange marriages of younger family members, ascribing family responsibilities and manage family property. Female members seldom get consulted over important issues regarding family matters. A particular family structure defines its women's status and autonomy enjoyed by her in the household. A woman in a nuclear family is comparatively independent to organize her activities according to her wishes. Whereas in extended family the situation would be totally different. The older women in the joint family enjoy greater mobility, access to resources and more decision making power. Moreover relation among women in extended family are apparently peaceful yet marked by mutual jealousy, antagonism and rivalry (Sanauddin, N., 2005).

In Pathan society like other conservative cultures, women are only allowed to interact socially with men to whom they cannot marry called the *mehram* (Sanauddin, 2005) Although in real practice women may not follow the strict rule of social interaction yet it influences their relation with non-kin male members. Patriarchy requires that women as a property of the family, and by extension, of the community are responsible to uphold the honour of not only her family but the whole tribe. A Pashtun woman is idealized as the one who embodies *haya* - modesty and observes *sharam* - shame -. Girls from childhood are expected to observe reticence, refrain from speaking among men or laugh loudly. Young girls are demanded to observe *purdah* from early age and abstain from mixing with boys or crossing the home boundary. The restriction on girls' physical movement is

placed in order to uphold and safeguard family honour and male members' respect. Restricted by these rigid traditions, women spend their whole lives fearing from tarnishing their family honour. (Sanauddin, N., 2005).

## **CHAPTER 3**

### **Research Methodology**

#### **3.1 Research Design**

The aim of this research study is understand the challenges faced by the female patients due to the prevailing cultural norms and limitations, while visiting primary health centers and consulting male doctors. For this purpose, qualitative research study is undertaken to better understand the social issues.

A research study is classified according to the purpose it serves. It could be exploratory, explanatory or descriptive in nature. The given research study sits well in the frame of explanatory research. Explanatory study is the kind of research taken up when there is some basic idea already available about the subject and the researcher wishes to explain the topic further. There has been considerable work done on patient interaction with gender – discordant doctors and their communication issues etc. However, the culture perspective between female patients versus male physicians in Pakistan and in KPK especially has not been noticed significantly. Therefore, the purpose of this study is to explain and take the topic further.

This study is qualitative in nature and makes use of rapport building, informal interviews, observational and structured interviews to extract detailed, comprehensive and in-depth information on the given subject. Three BHUs – Pishtakhara, Gulshan Rehman and Palosai in the suburbs of Peshawar were selected. I visited these units in the months of January and February 2017. A preliminary pilot study was also conducted previously at BHU Phulgran in the suburbs of Islamabad. This pre-testing phase provided with an excellent opportunity to get considerable amount of first hand raw data. This rich information gathered was analysed and organized and subsequently set the stage for further probing the issues and challenges prevailing in the actual BHUs of Peshawar district.

### **3.2 Units of Data Collection**

The Units of data collection for study were selected as follows:

- Female patients at Basic Health Unit
- Male Doctors at Basic Health Units.

### **3.3 Sampling Strategy**

For a social scientist, generally there are two kinds of data of interest: individual attribute data and cultural data. Both data require different kinds of sampling approaches. The individual attribute data as the name indicates would involve individual characteristics or attributes of a population like age, income and education etc. If the objective is to estimate a population parameter then randomly drawn, unbiased sample is to be selected (Russell, 2011).

On the other hand, cultural data involve cultural facts and information for which we would require cultural experts who would share explanations about the prevailing cultural norms and about variations in that norm if any. Hence, individual attribute data requires probability sampling and cultural data would require non-probability sampling (ibid).

Since this research that I undertook is of qualitative nature, non-probability sampling techniques are of main interest here. In qualitative data, it is not necessary to collect data or information on every member of the community in order to acquire valid findings. Only a sample of the population is to be selected for a given study. Generally, the type of sample to be selected depends greatly on the research objectives and population characteristics under study. The most common sampling methods used in qualitative study are quota sampling, purposive sampling and snowball sampling (Mack, 2005).

In purposive sampling, while deciding about the sample size we consider the research objectives as well as the time and resources available. Another important criterion for determining the purposive sample size is the theoretical saturation – a point in time reached during data collection, when additional units of data do not bring in any new

insights into the research question. Purposive sampling is the most suitable when data analysis and review are carried out in conjunction with data collection (Mack, 2005)

Purposive sampling is one of the most commonly used sampling strategies. The participants are grouped in to the sample on the basis of a pre-selected criterion relevant to a particular research question (Bryman, 2015) for example - number of female patients visiting male doctor at BHU. For this research work, purposive sampling was considered most suitable and appropriate type of non-probability sampling technique. As per the definition of purposive sampling the participants are selected according to the criteria of their having relevance to the research question. So we decide upon the purpose we want the informants to serve and then include the participants in the sample. Hence, the type of respondents decided in relevance to the research question, were the female patients visiting male doctors at primary health centers.

For the purpose of this research, primary level health care units were focused upon. Three BHUs from Peshawar district were selected.

- 1) BHU – Pushtakhara
- 2) BHU – Gulshan Rehman
- 3) BHU – Pulosai

From each BHU 8 female patients were selected and interviewed as they came along. 3 male doctors in total, one from each BHU were selected. Moreover, 2 LHVs and 1 MT were also included in the data.

### **3.4 Research Methods**

In depth interviews, observations, informal interviews and rapport building methods were used in data collection. Three BHUs in Peshawar district were selected and visited during the months of January and February, 2017 with the aim to closely observe and gather information on the working of the BHUs, female patients and the medical staff. Interviews were conducted with the female participants in the waiting room of the facility and in the LHV's room depending upon where the patients were available.

### **3.5 Ethical Concerns**

The research study was conducted with great care and caution, respecting the cultural needs of the local people and keeping in view the ethical considerations for the study to ensure that the privacy needs, rights and modesty requirements of the participants are entirely safeguarded. Before the field study was conducted, an official confirmation was obtained from the Director General Health, Provincial Health Department, Peshawar, KPK, to carry out the interviews and research work in the designated Health Units in the district. Since, the study was taken up in my home town, I was already acquainted with the local contexts, mores and general sensitive issues regarding gender and religious beliefs.

Special care was taken to maintain the anonymity and confidentiality of the patients and the medical staff. Prior to operationalizing the interviews, all the participants were explicitly informed about the purpose of the study, conducting the interviews, major issues to be discussed and that their participation was voluntary one and their identities shall be protected. The participants were clearly informed that all the data collected was for academic purpose only. In this way, I was able to ensure all my participants about keeping their confidentiality intact and giving them enough confidence to come forward voluntarily and participate in the interview process.

#### **3.5.1 Observation**

Participant observation is considered as the foundation of cultural anthropology. It requires getting close to people, establish rapport with them and make them feel comfortable enough with our presence so that we can observe and collect information about their lives (Bernard, 2006). Observation is said be a method of gathering data by watching closely the behaviour, events and physical characteristics of the subject in their natural setting. (CDC, 2008). It is about experiencing the lives of the people as they are. Observation involves following the culture in the wild and establishing rapport with the people so that their business goes on as usual when you show up. (Bernard, 2006)

The step involved observation of patient – doctor consultation. The female who consulted the BHU doctor in majority of cases came for their sick children who were having fever, ear or throat infection or dysentery etc. In least number of cases it was observed that some females who were accompanying their children to the doctor would also try to share their minor health issues with the doctor like asking for supplements or a general advice on loss of appetite or dizziness etc. majority of the female patients with general health issues or gynae related health issues went straight for the LHV. Moreover a considerable number of females visited the BHU for vaccinating their infants and consulted the male medical technician in that case. The non-participant observation process involved observing medical consultation process of the female patients viz-a-viz the LHV and male doctor. The medical consultation included history taking and general physical examination (of the exposed parts of the body like eyes, nose, throat etc.) of female patients by the LHV and male doctors where required

### **3.5.2 Key Informant:**

According to Bernard (2006), good key informants are people to whom we can talk to easily, who understand the kind of information we need and are glad to share it with us. The best key informant would be the one who is cynical about his own culture. Bernard, (2006) opines that such people are more observant and reflective about their culture in a rather discrete way. A good ethnographic study builds on the mutually supportive relations with a few key persons (Bernard, 2006) and our job is to find such dependable and reliable informants.

During the pilot study phase at BHU Phulgran, I was able to gather substantial amount of data with the help of one such key person – an LHW, who had been associated with facility for the past many years. She explained to me all the common female health issues and morbidity issues prevailing among the females of the area. I was able to learn about the gynaecological problems and family planning issues that women had and how they were treated at the BHU. During the study of selected BHUs in Peshawar, the key informants were an MT and LHV at BHU Pushtakhara who helped me in understanding

certain key issues prevailing in the area. They explained in detail the working of the facility, doctors available, women patients frequently visiting the BHU, their problems and about the community. Their input gave a holistic view of the prevailing social and health issues in the community.

### **3.5.3 Rapport Building**

It is considered one of the most important data gathering instruments in qualitative research by initially building an acquaintance with the people of the locale and the settings. When we enter a new field situation, we seek to gain as much raw information as possible by asking a lot of questions. However, if we ask too many questions in a new situation the possibility is that we may get unreliable or even incomplete data. By just hanging out with the local people or be around in the situation builds trust or rapport. This rapport building develops confidence in people to share their ordinary conversation and honest information with the researcher (Bernard, R; 2006)

During this phase first the LHVs were included in the informal chat process as a ground-breaking data gathering source, in order to get the feel of the BHU environment, it working and the visiting patients their whereabouts etc. Similarly, male MTs present at BHU working along with the male physician were also enquired about the working of the health facility in informal way, the patients who visited the doctor, their case histories etc. Rapport building process was like 'ice-breaking' phase for me to get comfortable with the new environment and more especially make my respondents comfortable with me, by getting to know them a little better before asking them structured questions.

In the first stage, semi-structured interviews were conducted with female patients visiting BHU as patients themselves or accompanying their wards/children. The aim was to cover upto 30 patients from 3 BHUs. However, it was observed that after collecting data from 6 to 7 patients at the most saturation point was reached i.e. the output yielded same information with any new ideas emerging. So in total 15 female patients at three BHUs were sampled and interviewed. Likewise, semi-structured interviews were carried with 3 male certified doctors working at the given BHUs.

Structured interviews were not included here as the scope of the study does not involve getting identical set of responses on predetermined questions but rather explore the issues faced by female patients from their perspective.

#### **3.5.4 Informal Interviews**

According to Bernard (2006), informal interview is marked by a total lack of structure or control. The researcher has to remember all the information gathered through conversations during the day. This requires constant taking down of notes and comprehensive sessions producing field notes. Informal interviewing generally is a method of choice at the start of participant observation in fieldwork, when one is getting acquainted to the new surroundings (Bernard, R; 2006).

Informal interviews were conducted with a considerable number of people including female medical staff, LHV, LHW male MT and some female patients and female visitors accompanying patients and children at each BHU. This kind of interviews helped me to collect information even beyond the scope and purpose of the research topic. The participants disclosed about the prevailing problems faced in the facility and the community as well. It helped in putting together all the pieces of information by having the contexts explained and getting a holistic perspective on female patients' problems. For instance, most of the female patients visited the facility early morning and tried to get done with their checkup as early as possible. The reason was that they had to reach home and finish their household chores before noon for their husbands and children. For female patients whose residences were at greater distance from the facility preferred to either go to their local medical practitioner or stay home and bear the pain or illness rather than come to the BHU. Hence, distance from the facility, male doctor presence and limitation on the mobility of the females placed serious impediments in the way of their access to health.

### **3.5.5 Unstructured interviews**

Also called the unstandardized, informal or non-directive interview, it is carried out with the assumption that the researcher does not know in advance what all questions would be involved in the study so one cannot predetermine the list of questions to enquire (Berg, 2001). Unstructured interviews are most desirable in situations which require building initial rapport with people, before embarking on more formal interviews. It is considered more suitable for candidates or respondents who cannot handle formal interviews well. This kind of interview is characterized by a minimum amount of control over the respondents' replies. The idea is to allow participants to express themselves in their own way (Bernard, H. R; 2006).

Ethnographic interviewing is mostly unstructured. In this study, the topic of conversation during unstructured interviews remained focused on female patients' access to health care and their interaction with male doctors at BHU. Through unstructured questions and probes the informants were encouraged to provide information worth sharing. In this research study, unstructured interview were of benefit as the respondents - female visitors/patients and lady health workers were coming from varied and diverse geographical backgrounds. Informal interviews and further probing yielded variety of information. Ethnographic interviewing mostly involves unstructured pattern. It is not appropriate to ask exactly same, closed-ended questions from all of the respondents considering their multifarious background, experiences, ethnic culture, family, lifestyle, education, health conditions and income levels. Where the intention is to document about the lived-experiences of particular people - in this case female patients interacting with male physicians - unstructured interview renders better results. This type of interview becomes useful when the aim is to establish initial rapport through 'chitchat' (Douglas, 1985) and familiarizing with the respondent's background.

### **3.5.6 Semi-structured interview**

Lying between the continuum of completely structured and totally unstructured interviewing is the method of semi-structured interview. It is a combination of both

structured and unstructured interviewing. It involves introducing a number of questions in a particular sequence yet allows the interviewer to digress and probe more even beyond the selected questions (Berg, 2001). This type of interview gives the interviewer some leverage and manoeuvring on questions and also offers greater information sharing by the respondents, similar to informal interview.

In the given research under study, each respondent – the female patient was asked a set of predetermined questions in a given order and the respondents were allowed to respond accordingly with their own experiences. The semi-structured interview would start with initial structured probe – 5 to 6 questions pertaining to their socioeconomic background i.e. age, education, marital status, children if married, husbands' job and wage level and family system – nucleus or joint family etc. then their health problem or reason for visiting the health center was enquired etc. after this further free guided questions let the respondent disclose information as much as possible with least interruption. The topic was approached from the respondent's' perspective – how she felt about the given issue. This was accomplished well by unstructured probes.

At the proposal stage, it was envisaged to incorporate one case study method to reinforce and enrich the data. However, the method was not included in the final stage due to the abrupt contraction of time allowed by the Institute. Nonetheless, through informal interviewing and semi-structured methods from female patients, male doctors, male medical technicians and LHVs at the BHUs enough data was generated to support the research study's aim and objectives.

The BHUs in the rural suburbs of Peshawar district were selected to highlight the status quo situation of the primary health centers, inadequate facilities in terms of logistics and appropriate medical staff i.e. lack of female doctors or even male doctors, challenges faced by the visiting patients particularly females, their demands and on ground realities. The idea was to feature the gap between short supply of and in excess demand for health services by the female patients. The reason to pick BHU is because it is the primary or first line of health center for catering to the basic health issues of needy people especially women and children in far-flung areas. If these centers are adequately staffed and well equipped the health objectives of the government would be fulfilled and general rural

population especially women and children would lead healthy productive life. However, on ground realities of these centers are far from being satisfactory. The wide gap between policy work and ground reality of these centers led me to focus my study on them. The second and third tier hospital like government teaching hospital and satellite health facilities were not accommodated. The reason being that these facilities have relatively better health services with bigger ratio of male-female doctors available and also better logistics. Hence, female and male patients go to these hospitals by choice and they have access to any female and male they wish to consult. The challenge to female patients is faced in the primary health units which although are in the rural and suburbs of the city but do not have female qualified doctors available for female patients.

### **3.6 Data Analysis Techniques**

The frame work method has been widely used for the management and analysis of data for past few decades. This method was initiated primarily for large scale policy research works but is becoming an extensively used approach in medical and health research fields and beyond. It is remarkable tool for supporting thematic or qualitative content analysis as it provides a step-by-step systematic method for organizing and managing large data. It is also the most appropriate method for the analysis of interview-data where one wishes to generate themes (Gale, 2013).

The analysis for qualitative research can be done by a number of approaches: discourse analysis and ethnomethodology – which pays close attention to the language used and how it is used in given social interactions; phenomenology and narrative methods –which are more concerned with the language, its meanings and experiences and the Grounded Theory which seek to develop a theory from the data collected through a given set of procedures. Most of these approaches have roots in some philosophical ideas that then shape the analysis process. The framework method on the other hand is dis-aligned with any such particular philosophical, epistemological or theoretical ideas. On the contrary, it is a flexible method that can be used for various types of qualitative data that desires to generate themes (Gale, 2013).

Its most defining feature is the use of matrix system i.e. use of rows and columns and individual cells containing condensed data in summarized form, providing a complete structure where in all of the data is scientifically reduced or condensed to be investigated by cases by case (row by row) and codes by codes (column by column). The case could be individual interviewee's data or even other predetermined units of analysis like groups or organizations' data. The Framework method hence provides distinct step-by-step process to follow and subsequently generates a highly rich and structures analysis of summarised data information.

For the Framework method to be successful, heterogeneous data should not be adopted for analysis i.e. the data need to cover common or similar themes and issues that are possible to categorize. The framework method is most widely used for thematic analysis of semi-structures interviews or transcripts and also for other textual data types like documents on field notes from observation, minutes of the meeting or diaries (Gale N, 2013),(Jones RK, 2000), (Pope C, 2000).

Keeping in view the appropriateness of this approach to the research study conducted, I have undertaken Framework method for the analysis my data. Accordingly, all the required steps or stages involved are executed, namely, transcribing the data, familiarizing with data collected, coding, generating themes and lastly, interpreting the data.

### **3.7 Pilot Study – BHU, Phulgran, Islamabad**

In connection to my Mphil thesis, I took a short field study visit to one BHU in Phulgran area of Islamabad. The reason for this preliminary study was to get acquainted with the ground realities, BHU system and working environment, medical staff present and types of patients visiting the primary care. This visit eventually helped in understanding the overall health care structure of the country and obstacles faced by the patients as well as the medical staff. It also helped me to chalk out subsequent interview guide for the final fieldwork required in the thesis.

I took the pilot study on January, 15<sup>th</sup> 2016; around ten in the morning. It was extremely cold and foggy day. BHU Phulgran was a single storied building with three separate room, tiled floors and walls. Cleanliness wise it was well maintained but logistics wise poorly maintained with some broken furniture and somewhere no furniture at all. Doctor's room was on the left side with frugal supplies, broken chairs or missing, and examination bed cover was badly torn with inside foam coming out. Adjoining central room is for medicine dispensing looked after by Incharge Dispensary who basically was a non-qualified compounder. The third room on the right end is for meetings of lady health workers and visitors of the area and share their feedback.

The BHU is under the charge of one Medical Assistant Mr. Iqbal Zafar a non-MBBS practitioner and an LHV who was infact absent from the post for past two years. Cases of all advance female or gynaecological problems were referred to Rural Health Center RHC, Barakaho which some twelve to thirteen km away.

**Basic Health Unit:** One Union Council is supposed to have one BHU. Four BHUs come under 1 RHC Rural Health Center.

1 UC = 1 BHU

4BHUs = 1 RHC

For example: RHC Barakaho = 1 BHU Phulgran

= 2<sup>nd</sup> BHU Shahdrah

= 3<sup>rd</sup> BHU Pind Bigwal

= 4<sup>th</sup> BHU Shah Allah Ditta

The Basic Health Unit assists in combating or curing minor ailments like flu, cough, fever and diarrhoea etc. It screens at preliminary level and checks for any major complications that need immediate referral to RHC or even District level hospital.

A BHU is First Level Care Facility or FLCF only. It is setup with the objective of maintaining primary health of the community i.e. to maintain family hygiene and healthy life of a family. The Phulgran BHU is attached with 8 LHWs and 1 LHV - a mandatory post, while the employee is absent for past two years.

RHC Rural Health Center – RHC, Barakaho is bigger than BHU in terms of resources and staff. There are 3 Medical Officers – MBBS doctors – 2 male and 1 female. There are also 2 Medical Assistants and 1 LHV. There are 3 work shifts:

Morning 8am – 2pm

2<sup>nd</sup> shift: 2pm – 8 pm

3<sup>rd</sup> shift: 8pm – 8am

The first shift is for OPD, while the 2<sup>nd</sup> and 3<sup>rd</sup> shifts are for emergency cases involving natural delivery. In case the patient develops serious life-threatening and emergency condition like excessive bleeding during labour, appendicitis and hernia they are referred directly to District level Hospital PIMS, Poly Clinic or even some private hospital depending upon the patient's financial resources. Note that no medical conveyance, carriage or ambulance is available at any time in these areas. In case of emergency the patient and her family has to arrange the transportation themselves.

District Health Officer DHO – an MBBS doctor is in charge of the RHC. Every month a detailed Performa report is sent by each BHU to RHC.

The performa report shows detailed breakdown of visiting patients according to their gender, age, disease etc.

Lady Health Worker LHW programme was initiated in 1994 to facilitate people especially women and children in far flung areas with health conditions. An LHW is the permanent resident of the community and accessible at all times to the community. Their minimum education requirement is class 8. They are trained and authorized in providing curative practice in fever, flu, cough, and diarrhoea and prescribe medicine like aspirin, paracetamol and even in some cases antibiotic like Amoxil for fever and minor infections.

Lady Health Visitor LHVs are more advance in their knowledge and curative practices. Their minimum educational requirement is grade ten. After that they take course of two years in Lady Health Visitor and midwifery. They are recruited by the Government as

government employees and posted in BHU and RHC. They are trained and authorized to assist the female physician at BHU, provide assistance in minor ailments and family planning practices like administering IUD (coil) and injections. However, these family planning medicines were not available at BHU Phulgran for which the client has to be sent again to RHC. Female gynaecological problems like leukorrhoea are treated by LHV at BHU and RHC or could be referred to District hospital. Every fifth case of child delivery must be referred to District level hospital, it cannot be conducted at BHU or even at RHC.

### **Preliminary Findings:**

- Female patients OPDs were not comfortable communicating their health problems especially gynaecological problems like pregnancy, menstruation, likorea and urinary issues etc. with male medical assistant MA at BHU.
- Women patients usually do not even allow simple blood pressure apparatus to be used on their arm and stethoscope to be used on their stomach or chest. They either feel shy or very uncomfortable with male medical personnel doing it.
- Pregnancy screening tests need to be done by a lady doctor or by LHV as it involves information on woman's menstruation cycle, time of marriage etc. which could not be taken by a male person keeping in mind our culture and modesty needs.
- Gynaecological problems like irregular or missed cycles, excessive bleeding, likorea, itching and infection in urinary tract are all female private problems that cannot be discussed with a male medical assistant but only with a lady doctor or LHV.
- Phulgran BHU has 8 LHWs. Each LHW visits 5-7 houses daily making at least 2 referrals of female patients with gynaecological problems to RHC.
- For daily attendance each LHW has to come in person to BHU for signature and has to travel up to 4km distance of hard mountainous area, paying taxi Rs. 250 every day.
- Their monthly salary is Rs. 7,000 only. For the past five months no salary has been paid to them.
- Female patients who came to Phulgran BHU demanded LHV who remains absent from her post for past couple of years. The female patients and health worker offered an alternative in the prevailing condition that a lady doctor from RHC should come and sit in BHU twice a week. This will immensely accommodate the female patients and cater to their health issues resolving 'cultural barrier'.

## CHAPTER – 4

### Data Presentation and Analysis

This chapter brings to light all ground realities and facts regarding functioning of BHUs, medical staff available and serving and types of patient treated. The analysis in final form has been divided into three broad areas or themes: culture, communication and preference for female physician. All these three areas present considerable amount of challenges for female patients in form of inhibition, barriers while interacting with male doctors, due to the non-availability of female physicians.

The BHUs are opened with the objective of safeguarding the health of mother and the child and provide protection against common diseases like flu, fever, cholera, dysentery and infection etc. The facilities receive large number of female patients as compared to small number of male patients on daily basis. The male and female patients are treated mostly by the male doctor present on duty and an LHV at the facility. The female patients visiting the BHU were segregated together away from male patients and questioned according to the health problems they came for, namely:

- i) General health problems: flu, fever, diarrhoea, cholera, dysentery, gastroenteritis, chest-throat infection, blood pressure etc.
- ii) Minor female health problems: all minor female, gynaecological issues that could be treated at the BHU – likorea – the most common complaint among women visiting BHUs or PV discharge – requiring injections and vaginal and oral medicines, dysmenorrhea (scanty and painful period), menorrhagia (abnormal heavy bleeding), itching of the vulva, ante-natal problems – weight gain or loss, blood pressure, breach, hypertension and ultrasound test required during pregnancy.
- iii) Advance female problems: heavy bleeding – menorrhagia requiring ultrasound and medications and even minor surgery, delivery, caesarean, missed abortion, hypertension, pregnancy tests, IUD, contraceptives including surgery of tube. These problems are treatable at relatively larger health facilities – secondary and

tertiary government hospitals and private clinics. Minor and especially major female problems are mostly consulted with female gynaecologists.

**Table 1: Socio-economic Classification of Female Patients**

S.E. Data Patient	Age	Education	Job/ Income	Marital Status	Children	Husband's Job/ Income	Family Setup
Saima*	20 - 25	Illiterate*	None	Yes	4	Daily Wager	Joint Family
Nadia	20 - 25	Illiterate	None	Yes	1	Daily Wager	Nuclear family
Najma	20	Illiterate*	None	Unmarried	None	None	Nuclear family <sup>1</sup>
Haji Bibi	25 - 30	Illiterate*	None	Yes	4	Daily Wager/Tonga - Rs 600	Nuclear family
Saida	25 - 30	Illiterate	None	Yes	4	Daily Wager	Extended Family
Sadia	13	Literate - Class 4	None	Yes	None	Taxi Driver/Rs 1000	Joint Family
Baseerat	30 - 35	Illiterate	None	Yes	7	Mechanic in Saudi Arabia	Joint Family
Salma	25 - 30	Literate - Class 10th	FCW /15K	Yes	5	Garage mechanic/Rs. 600	Joint Family
Zeenat	35	Illiterate*	Religious tuition to kids at home	Yes	4	Vendor/Rs 600	Nuclear family
Shakeela	30	Illiterate	None	Yes	6	Daily Wager	Joint Family
Taj Bibi	40- 45	Illiterate	None	Unmarried	None	None	Nuclear family <sup>2</sup>

*Table 1: socio-economic classification of the female patients interviewed at three BHUs*

\* Name of all respondents changed for ethical reasons

Illiterate: No education at all

Illiterate\*: No formal education - only learnt the Holy Quran

Nuclear family<sup>1</sup>: Living with parents

Nuclear family<sup>2</sup>: Living with brother's family

Table 1 shows the socio-economic classification of the female patients interviewed at three BHUs. The first column gives the approximate age of the patients, since they were not aware of their exact ages. Therefore their ages are mostly given as an approximate figure, as revealed by the patients and my own estimate.

Most of the patients' were in the age bracket of 20 – 35 years, with two outliers. One patient, a 13 year old female who was first-time pregnant, 4 months gestation and one a 40 years plus, unmarried and living with her brother's family. More than 80% of patients interviewed were illiterate with no formal education. Only one patient had passed secondary school and one had studied till class 4<sup>th</sup> i.e. 18% of the total patients interviewed.

For the financial support all these patients depended on their husband's job or other male members of the family. Their husbands' were daily wagers earning less than Rs. 1,000 a day on average. The average number of children in each family was 4. And majority lived in combined families. This aspect revealed an added responsibility on them in terms of looking after their parents-in-law along with their own children and husband. Respecting the decision of the family elders regarding all of their private and social issues was imperative for them.

The three BHUs which were visited were found wanting in providing complete health care services at primary level. There was one male doctor available along with one male medical technician MT and one LHV checking female patients in a separate room. It was observed that due to the non-availability of female physician at the BHU, female patients tend to go to multiple health facilities for seeking similar health care solutions. For instance, for general health problems, the female patients would either visit BHU if near their residence or go to the village male doctor. The village medical 'doctor' or practitioner as pointed out by the local MTs and the male doctor in the BHUs I visited, is mostly a medical technician himself or even a lower cadre medical staff, who runs a medical facility at the local area for checking patients and delivering health services at primary level. The local people – men and women alike visit him for almost all of their health related issues. The standard procedure of the treatment in this case is usually to

give injection and some medications basically to assuage the physical distress of the patient without any detailed or thorough examination and check-up.

The reason for the female patients to visit the village male doctor is mainly the proximity to their homes and secondly the level of trust, credibility and comfort level achieved with the male practitioner, over the course of many years that he had been practicing in that local area. Consequently, all the people in the area revere him and attach great value and credence to his advice and adage. The village doctor also happens to belong to the same village and everybody knows him well. Infact, many of the female patients who ritually went to the local village doctor noted that they had been going to him since their childhood, sometimes without accompanying their parents. Hence, there was a level of reliance and believability achieved with him which was not possible with the male doctors serving on duty in the BHU. This local village doctor was given a reverence and place of a senior family member because of his extensive practice in the area, experience and age.

Secondly, for minor female issues, the female patients visit the LHV at the BHU or again the village medical practitioner if the BHU was not in proximity. The female patients also went to female village medical practitioner for ultrasound tests and problems that involved physical examination. These female practitioners, it was learnt are generally the LHV serving at BHU, who have set up private practices in their vicinity to check female patients and their children charging some amount. It was also observed that despite the presence of qualified LHVs at the BHUs, the necessary medical equipment was either not available, broken or out-of-order. One LHV complained that their ultrasound machine was broken for the past couple of years but despite their numerous requests nothing was done. Similarly, the examination bed for female patient and even male patients was dilapidated. Surgical and medical supplies were not available on timely basis in the BHUs. Hence, due to the lack of female physician in conjunction with appalling conditions of the facility, lack of necessary equipment and facilities, these female patients had to visit numerous health facilities at a higher cost and time.

For more advance female health issues, they opted to go to secondary or tertiary government hospital to consult female gynaecologists. The female patients also

mentioned going to private clinics for female doctors as the government or public hospitals were too crowded and at times they would not get the chance to see the doctor. Hence, additional costs were incurred at private clinics, for the treatment of the same problem that were manageable at primary centers. All these hospitals were at much distance from the patients' residence. This created additional burden on the family in form of time cost, travel expenditure and medical test fees. The costs further increased in case of visiting a private facility and private doctors. All these factors combined to serve as an inhibitor for female patients to get an easy access to health care.

There was a great congruence found between the responses recorded by the female patients and the observations made by the male doctors present at the BHUs. The cultural barriers faced by the female patients during consultation process and communication were equally felt by the male doctors. The latter however, had no problem in discussing the health issues of any kind with their patients as they were trained professionals, but noted that due to the existing cultural norms they were bound to respect the modesty of their patients and be highly sensitive towards the cultural, social and privacy needs of their patients. The male doctors were of the opinion that all patients must as a rule must consult the doctor at the BHU instead of going to the LHV. As the latter are not qualified for the job of diagnosing and treating patients and prescribe medicine or antibiotics to patients. Rather the LHVs are a support staff assisting female doctors. However, generally only female patients suffering from serious general illness like UTI, severe abdominal pain etc. or female-specific problems like menorrhagia, leukorrhea etc. were brought to the male doctors' room by the LHV for prescription of medicine. .

#### **4.1 Culture as a Barrier**

Majority of the patients visiting the three BHUs were female patients. They were either visiting the facility for themselves or for their children. For children, the respondents also consulted the male physician present at the BHU but for their own health issues they would consult the LHV present at the center.

#### 4.1.1 KP and Purdah Culture

Due to stringent purdah culture, female patients preferred to consult a female doctor for all health issues especially minor and major female health problems like likorea, dysmenorrhea, missed cycles, contraceptives, pregnancy etc. In case the lady doctor was not available at BHU then the female patients would go to the LHV rather than to the male doctor who is a certified MBBS doctor was also present at the facility. One female patient Saima, at BHU Gulshan Rehman, who had come to vaccinate her baby, mentioned culture barrier like this:

*Because of purdah culture and 'haya' modesty, I prefer to remain home rather than take my female issues outside. In case of general illness like fever and flu and even minor female health issues, I have borne the pain but never visited a doctor. Only for pregnancy, I had to go to the big hospital such as Naseerullah Babar hospital which is quite far but because female doctors are present there.*

Moreover for other problems which required medical tests like ultrasound or physical examination, female patients went to their local village lady doctor, who would be a medical assistant or staff only, having opened a private clinic in the local area for the females to have easy and quick access to ultrasound test during pregnancy and follow-up check-ups.

It was also observed that when female patients came for their general problems, like flu or cough, they were sent directly to the LHV room by the male receptionist at the front gate. The male attendant would make the referral slip for all female patients to see the LHV, even though the male physician was present on duty. The female patients were not asked whether they wanted to consult the physician or go to the LHV. When asked, one patient Razia said:

*We are females and the male attendant knows we are shy and observe purdah so he sends every one of us to see the LHV. Although she is not a doctor but she is a female and we have no privacy from her.*

Another female patient Taj Bibi, who was a spinster and in late 40s said:

*Young girls and spinsters should not visit male doctors openly. This is not our culture. It is important to be modest and be shy of visiting a male doctor. Under 'burqa' with face covered, I could tell the problem to the male doctor, but still I would prefer going to a female physician.*

#### **4.1.2 Family Permission and Male Doctor**

All the female patients visiting the BHU came accompanied by their family members like mother, sister, and mother in law or husband etc. Females either came for their ailing children, accompanied by their husbands mostly or mother or sister etc. and they would consult the male physician in most cases. When a female patient came for herself, she was always accompanied by a female family member – mother in law, sister, mother etc. this way they felt secure while consulting the doctor and they would only go to the LHV room. Moreover, the family also chaperoned the female patient this way. These female did not mention about any restriction from the family as such to visit the doctor for their children or themselves. However, these female patients were only 'allowed' to see the LHV for their health issues and not the male doctor.

On the other hand, female patients who visited their village male doctor during illness were allowed by the family and also accompanied her during consultation with the male doctor. It is to be noted, that *male "village doctor"* as termed by the patients was generally a medical technician or a para-medic staff member who usually sets up a small practice in his local area and is renowned as a doctor by the local people. Female and male patients alike visit him for all general health problems and even for minor female health issues like likorea etc. Infact patients believe that doctor by definition is a male (Gallant, n.d.). When female patients were asked how they could go to a male health provider, Saima explained like this:

*He is from our own village, everybody knows him. I have been going to him since childhood. Even my parents sent me to him when I was small. I can tell him my (minor health) problems.*

This showed a level of trust, confidence and credibility attained by the male village doctor. Due to their experience and age, the village doctors are highly respected and trusted and regarded as a parent hence the female patients felt safe and comfortable even discussing minor female health issues with them. As one of the young female respondent Shamshad said about going to the male doctor:

*Che doctor she no mor o plaar shi – (A doctor is like a mother or father)*

Patient Haji Bibi from BHU Gulshan Rehman, while explaining the reason for going to the male village doctor explained:

*He knows us well; he is a good doctor and understands our problems well. I know him since childhood and his treatment and medicines are efficacious. Once I had a bad experience at a big government hospital for some reproductive health issue so I went to our village doctor next time for likorea and I was satisfied with his treatment.*

Doctor Samad mentioned:

*The husband is the bread-earner of the family. He gives his earnings to the wife, takes care of her living, clothing, shelter so then he also decides for her as to where she should go and whether to go to male doctor or female.*

#### **4.1.3 Resistance from Male Community**

The male members of the family of all the patients allowed them to go to a male doctor for their children only or for very general issues like flu, fever etc. in some fewer cases women were observed going to the male village doctor for very minor female health

issues like vaginal-discharge etc. but that was only in case the doctor was of the local area and had been practicing for a very long time so all the people knew him well and trusted him in his practice. Apart from that the males of the family strictly restricted their females from going to any male physician for advance female issue. In this case only female doctors were to be consulted, even if they were at very far distance. One female patient Salma at Pishtakhara BHU, was educated and worked as Female Community Worker FCW pointed towards male community members resistance and restriction on females from going to a male physician, even for general issues:

*These village people are not relations but they spread gossips about women who consult male physicians or go to them frequently in the village. They are grey haired men – mostly religious and Haji, so people have to listen to their opinion. They directly don't stop women but rather talk to their husbands so the men have to listen to them.*

She said that although she was educated and had not such restrictions of seeing a male doctor at time of distress but she would also pay heed to such judgments and be wary of it.

#### **4.1.4 Religion as a Cultural Barrier**

Although the BHUs have male physician present on duty, still majority of the females visit the LHV at the facility either by default because the patients are segregated at the entrance of the BHU through referral slip. Male patients and children with wards are sent directly to the male doctors' room and female patients are sent to the LHV room. One of the patients - Zeenat explained religion as the deciding factor for choosing to go to the female health provider. She said:

*It is God's order to keep away from males as much as possible.  
So I would always go to a female doctor in time of need otherwise  
retreat and go back home.*

Zeenat also pointed towards the overbearing aspect of culture and religions as a critical factor in choosing physician gender. She physically demonstrated how she would give the physical examination to male doctor, in case a female physician is not available.

*The condition is to be completely clad in 'burqa' from face to toes. Hold the stethoscope from the doctor and put it on the chest or body and the doctor could listen to the heart beat. Similarly for throat check-up, keep the whole face covered and reveal the mouth area only. It is God's will for females to keep away from male as much as possible.*

#### **4.1.5 Gender Preference of Doctor**

All of the female patients whether visiting a village male doctor in their local area or an LHV at the BHU universally agreed upon the fact that for general ailments flu, fever or diarrhoea etc. and in some cases of minor female problems they could go to a male doctor, preferably from their village doctor or the BHU. However, for all advance female health issues including pregnancy, contraceptives missed abortion, ultrasound, check-ups etc. they would only visit a female physician or even a female medical assistant – LHV, LHW or a female technician but no other. This condition was also strictly required by the respondents' family members too who would not allow them to consult any male health provider.

The male doctors also presented the same response that female patients generally went to the LHV for self-consultation either by choice or referred by the medical staff. In case the female patients came for female specific problems, which were not common, there would be an LHV accompanied and the doctor would recommend drugs and antibiotics and would ask about pregnancy in brief. Similarly, male doctors found female patients also avoided giving details of their illness rather the LHV would present the illness and take the prescription.

#### **4.1.6 Education and Culture Barrier**

Majority of the female patients who visited the health facility were either totally uneducated or had taken some religious lessons and could only read Quran. Only two of the female patients who were interviewed had acquired some formal education. It was observed that the opinions of female patients with and without education varied considerably regarding going to a male doctor. One patient who was educated up to matric – grade 10, came unaccompanied to the BHU. She also had no reservation consulting the male physician at the facility but went to the LHV room because of the referral system, whereby the medical attendant sends all the female patients directly to the LHV without first asking them. She was more liberal in her opinion about consulting male doctor for self however she quoted restrictions from the family – in laws, mother-in-law and neighbourhood due to which she did not opt for going to a male doctor.

Sadia who had studied till grade 4 also showed no reservation and reluctance in going to a male physician. However, for advance female health issue including reproductive issue she preferred a female doctor. This patient had come to the facility to get an injection for pregnancy from a male technician. She said that for general illness too she goes to the big hospital Naseerullah Babar Hospital with her husband and sees a male doctor over there. Upon further probing as to why a male physician was preferred over a female one, she opined that firstly because male doctors are more readily available than female doctors and she didn't have any issue along with her husband while discussing the health problems with physicians.

#### **4.1.7 Distance - a Cultural Barrier**

The female patients who visited the BHU were mostly from the same vicinity and nearby area. It was seen that most of them reached early morning between 8am to 9am, their influx peaked at around 10am and after that around noon time, the female patient inflow stopped. While the visiting females also left around that time except for some who came on emergency for children or for self. It was learnt that these female patients could only spare some time in the early morning, from their daily household work rituals. They all had to rush back soon and before noon, firstly because they had minor kids left at the house and secondly to get meals ready, do laundry and clean the house etc. before the children and husband arrived. This practice pointed to the fact that women have a

gendered role culturally modified to priorities the needs of the children, family and husband first. They could only spare a short time in the morning to consult the health provider briefly and then head back. Hence, only female patients who lived near the BHU could avail the facility services. But for all those females who lived at a further distance from the BHU and could not reach early morning would rather go to the village pseudo-physicians. This affected their treatment and health care.

Almost all the female patients as mentioned before came from lower income class, with no formal education and husbands working as daily wagers. At one BHU Gulshan Rehman, it was observed that many females had come to vaccinate their infants, from far flung and peripheral region of that area. However, these females had never visited the facility before for themselves because it was at a great distance from their homes. Some were migrants from Afghanistan, living in the local settlements. Since this BHU was at some distance and also no female doctor was available at the facility, it made it least desirable for these needy patients to come here for general checkup. Their collective response about the physician and the hospital which they would rather visit was either a village male doctor, a female doctor in the secondary or tertiary hospital which were at greater distance from their locality or even an uncertified, unauthorized female pseudo-doctor in their village for doing ultrasound test and check-ups. As one patient Najma put it:

*I came here to vaccinate my baby, as the injection is not available elsewhere. But for myself I cannot afford to come to here again as the distance is too much.*

Najma further added:

*For general problems and even female issues I don't go out preferably. However, in case the problem gets serious then I can go to the village doctor.*

The following tables in the subsequent sections show similarity between the views of female patients and male doctors on major issues of culture, communication and preference for female physician.

**Table 2: Congruency between Patient & Doctor on Culture**

	Doctor A	Doctor B	Saima	Zeenaat	Taj Bibi
Culture	Female patients in our society cannot openly talk with males let alone male doctors because of culture.	Majority of the patients coming to the BHU are females and consult the LHV. So the male doctor does not get in touch with these patients or prescribe them treatment.	Because of culture and purdah, I prefer to remain home in modesty rather than take my female problems outside.	It is acceptable to visit a male doctor only when female doctor is not accessible and on condition of completely disguising oneself in <i>burqa</i> so the male doctor cannot see us.	Young girls and spinsters should not visit the male doctors openly. This is not our tradition

Table 2: Congruency between Patient & Doctor on Culture

The table above shows that cultural norms and traditions inhibit female patients from visiting the male doctor or explain to him their problems. Women in some cases preferred to stay home, take self-medication and bear the pain as much as possible rather than going out to the doctor; or still in other cases go to unauthorized, unregistered healers - quacks - in the informal health sector, in their locality instead of going to the BHU having a certified male doctor. While for others, consulting male doctor was acceptable only on condition of observing strict purdah or *burqa* so the doctor could not see them at all.

Likewise the male doctors also felt the influence of culture upon their interaction with female patients. Although they were certified and trained professionals and gender of their patient or their morbidity type did not affect the doctor's ability to treat, scientifically diagnose the problem and recommend proper medication. However, despite the fact they remained cautious of the existing cultural norms and be respectful towards the modesty needs of their female patients. They felt compelled by the prevailing culture

and tradition as to not ask details about the female health problems and give them quick treatment and medication.

## **Discussion**

Health seeking behaviour among female patients and their health care utilization are profoundly influenced by and linked to the cultural milieu that they are part of. The health seeking manner among female patients reveal specific behaviour which follows religious factor and modesty requirements attached to their gender role, socio-economic status, household economics, distance, social support network, family decision making system, morbidity patterns and gender differences in patient-doctor dyad. Female patients showed proclivity towards visiting non-formal medical sector like village doctors and local female practitioner for general problems like upper respiratory tract infection, gastrointestinal infections and fever which were commonly sighted problems and minor female health issues including likorea, UTI, kidney pain and even early pregnancy check-up and ultrasound tests due to proximity of their services in the area.

Similarly a BHU in the vicinity with a male doctor did not serve much of a purpose as these patients were seen consulting the LHV present at the facility rather than the male physician. Due to the lack of quality service at primary level facilities, restricted operating hours, shortage of female physicians and distant location – an important factor - not much improvement is made in providing basic level health care to the female patients. Again most of these primary health units lack trained medical personnel i.e. female practitioners or has male physician available, this in turn presents opportunities for visiting unregulated medical sector dominated by untrained and unprofessional care givers like quacks, village doctors, local female doctors and health providers in private clinics providing unchecked health services. Family decision making by the male members also influence the patient's discretion ability whether to consult a doctor or an untrained female practitioner. Although some level of confidence was observed in going to a trained and certified male doctor at the BHU in patients who were a little educated.

Hence these socio-cultural barriers greatly impede health seeking attempts of female patients from modern medical facilities. The unwelcoming situation of these facilities entails poorer health status of the patients, slow improvement or even delaying and worsening their morbidity conditions.

## **4.2 Communication as a Barrier**

Communication between female patients and male doctors at the BHU were observed and recorded. The respondents being female patients visited the facility for general ailments and for minor female issues.

### **4.2.1 Difficulties in Consulting Male Physician**

While consulting the doctor for general nature ailments, presenting the illness apparently was not very hard for some female patients. However, the interesting fact was that female and male patients were by default segregated at the reception or entrance of the facility. The male patients were referred to the male doctor and female patients were directly referred to the LHV room by a male attendant at the reception. It was presumed that females would consult better with a female person than a male doctor. One patient, Razia who was visiting for herself and for her child stated the reason for not going to the male doctor present at the BHU like this:

*We don't know why, I came here (at the BHU) and went to the man outside (medical attendant) for a slip. He asked me about the problem and I said my child is ill. He gave me the referral slip and pointed towards the LHV room; to go in there.*

Similarly, Haji Bibi who had come for the vaccination of her baby of 6 months also pointed out:

*The MT in BHU gave the BCG shot to my baby. He did not send me to the doctor's room or refer us to the LHV.*

When asked if they would consult the male physician, some of the females confirmed that for their children and general ailment they would go to him if given an option than to the LHV.

Most of them came accompanied with one of the family members as a chaperone. In most of the cases where female consulted the male physician, they would present the illness and talk to the doctor. However, a few of the respondents stated that they were too shy to present their general problems so their mother or sister accompanied would talk to the doctor on their behalf.

#### **4.2.2 Communication Gap between Female Patients and Male Doctors**

One of the significant issues evolved through the discussion with the female patients was their presentation of the illness to the male doctor. The female patients while discussing their general health issues with male doctors tried to keep their explanation brief and short respondents also added short in case of minor female issues especially. They tried to remain as modest, discreet and reserved as possible. Hence the PI – presentation of Illness was in very brief form, although this part in the medical encounter between doctor and patient is the most important to reach a proper diagnosis and prescribe treatment accordingly.

Most of such cases went to the village male doctor, who in almost all the cases was not an MBBS doctor but a medical technician or even a lower cadre medical personnel having opened up a facility in their local area to make extra money. These women went to such village doctors, firstly because he was known to the local people and was a trusted and respected person. Secondly, he was in the same area and easily accessible. Therefore female patients preferred going to him even for their minor female problems than to the qualified male doctor at the BHU. Patient Najma rightly pointed it out so:

*I go to the village doctor (male) because I know him well and he is from among us. People know him and trust him with his treatment and medicine. He is considered credible. The male doctor at the BHU is a male stranger.*

The female patients nonetheless reiterated their communication barrier with the male doctor. All the patients clearly said that female physician was the most desirable thing in healthcare facilities for females. Patient Saida clearly stated her preference:

*Female doctor is better because I can tell all my problems, whether general or child health and also female issues openly – without hesitation!*

The respondents tried to keep the problem presentation as brief as possible with slight reference to the main issue with male physician. For instance, in case of likorea the respondent only mentioned that she was having 'white-water discharge' – a term used to infer likorea. Other than that no further explanation for the problems was given. It was learnt that the male doctors at the BHU and also the village male doctors of the village totally understood this reservation in the communication with female patients and were mindful and cautious about such modesty.

The male village doctors would usually give oral medicine or injections as a standard procedure. Most of the female patients though added that they would prefer to see a female health provider, if one was available or such a problem resurfaced next time.

Nadia, who had consulted the village doctor for likorea said:

*I told him in short that there is water-discharge problem and the doctor gave me injections and medicine for it. It gave me some respite from the problem.*

However, she preferred to go to a female doctor next time if the problem resurfaced. The female patients just give a hint to the existing problem. Details and extent of the female problem like likorea, contraception or pregnancy cannot be shared openly because of cultural norms and traditions which encourages modesty and reservation and shyness in front of men.

The female patients further added that they take previous test reports or medical records with them and the male doctors check the details from there. Zeenat said:

*I try to give a brief presentation of my illness and get the required medicine quickly. I abstain from detailed examination (and don't prefer it).*

The respondents said that they prefer a quick check up in case of male doctor and abstain from detail physical examination. For instance, while consulting a male village doctor for likorea, one of the female patients said that she told the doctor in brief that its more and the doctor gave her injections. Similarly another young female patient Sadia who was around 13 years, married for one year and first time pregnant, came to the BHU for getting an injection that is taken at 12 weeks gestation. The injection was self - recommended, which her relative said is taken by all pregnant women in their area as a rule so there was no need to consult a physician for this, she opined. Hence, they didn't go to any gynaecologist or get any referral but as a general practice got it done themselves from the MT – medical technician at the BHU. For pregnancy test and ultrasound she had gone to a private facility near her place where a female practitioner – not a certified doctor- checked her and did the physical examination. For children, the respondents did not have much difficulty in presenting or discussing the problem with the male doctor. In fact most visited male physician by choice. However, for advance female problems, the respondents regimentally consulted female physician or female medical staff only.

There were some few female patients who were reluctant to talk to the male doctor and so the accompanying mother or sister talked to the doctor on her behalf. While interviewing the male doctor same kind of response was received that some of the female patients let their (female) chaperone mother in law, *chachi*, sister or mother talk on their behalf with the doctor.

#### **4.2.3 Male Doctor's Communication with Female Patients – Management of the Problem**

This part analyzes male doctor's communication with female patients during medical consultation and management of the treatment. The female respondents said that during consultation with male doctors either at BHU or in their village, the health practitioner would inquire about the complaint only superficially or listen to the complaint only

briefly. The rest he would try to infer himself and recommend the medicine or injections. For instance, in case of giving injection as a pain killer or for fever, which is a common practice among village people to relieve distress, the male doctor would in a culturally appropriate and modest way ask about any chance of existing pregnancy or missed period etc. as the medication in that case could be harmful for the foetus and the mother.

Communication between female patient and Male doctor does not happen candidly and openly. Only casual reference is made to the female problem, while the doctor taking the clue based on experience working with the community would simply recommend some oral medicine. A modest, culturally appropriate and selective term used by male doctors for female patients in their local language is 'bemaari': which means general illness, but also used as an umbrella term to refer to gynaecological issues like menses or pregnancy, relevant to the case being discussed. A local MT Abdus Samad at Pishtakhara, BHU explained to me in detail the modus operandi in treatment of variety of female health issues:

*The village male doctor briefly asks about any existing pregnancy to give medicine. 'Bemaari' means periods, pregnancy and abortion. The doctor would ask 'do you have 'bemaari' or has it stopped?' Stopped would mean existing pregnancy so then he would change medication or the injection.*

When the illness or complaint is presented to the male doctor, for instance likorea which is quite common among females, no details are asked about the discharge type, its colour, odour and the discomfort felt because of the extreme shamefulness and embarrassment involved. The male doctor mostly the village doctor, as he is a known person in the area, practicing for long time and well respected and also because of the proximity of the clinic to the patients' residence is often consulted for minor female health issues. This raises an extremely important point of mistreatment and potential misdiagnosis of minor and easily curable female problems at the hands of unqualified and untrained male physicians, due to the rigid cultural barriers and resultant communication difficulties.

Despite the fact that the Village doctor is respected and trusted by the female patients and the latter come to him by choice, these doctors still refrain from going into details about female health issues even from their frequent female patients. They simply resort to the standard procedure of giving injection or oral medicine only without taking detailed history or further interrogation. Similarly for oral medicine prescribed for problems of dysmenorrhea, leukorrhea, for conception etc. no details are provided by the doctor about how to use it properly. Rozina another patient said:

*I visited our village doctor to conceive a baby. I told him that my 'bemaari' is not regular so he prescribed a medicine and told me to take it regularly for some time and that the problem will diminish.*

However, in reality medicines related to missed periods are usually of hormonal and cyclical nature. According to a consultant gynaecologist, Dr. Shirin Afridi, (Dept. of Health, Govt. of KPK) the medicines related to contraception etc. are required to be taken on alternate days i.e. some days on then stopped and then again continued for some time. Such details are generally not shared by the village male practitioners due to cultural reservations. These doctors refrain from giving out such particulars and simply tell the female patients to continue the medicines for a month or so. This way the problem is not managed properly and the medicine loses its efficacy leading to unsatisfied health goal. When asked if the same former patient above was able to conceive after taking the medicine prescribed by the village doctor, she replied in negative and added that she had done many such treatments earlier too but all in vain.

The scenario with the BHU male doctor was observed to be slightly better in the sense that if a patient came consulting for pregnancy or conception related problems, the male doctor would check the patient and then allow the LHV at the facility to convey the details of the correct dosage and medicine to the patient. The details about any precautions taken during treatment and the method of use of medicine are not discussed with the female patients by the village male doctors however. Moreover, other than oral medicine, the male village doctors also desist from prescribing any type of medicine

other than oral like vaginal medicine considered effective in vaginal infections or discharge, due to rigid cultural and communication barrier.

From male doctors' perspective, communication between female patient and male doctor does not happen candidly and there is an element of reservation and modesty observed on both sides of the dyad. Only a slight reference is given to the female nature of the problem avoiding going into details. The male doctor tries to take clue from the patients' presentation of illness and prescribes oral medicine mostly. The details about any precautionary measures, method of use of medicine etc. are communicated by the LHV usually.

According to one of the male doctors, if a female patient came for instance with abdominal complain, the required procedure would be to do the abdominal examination. However, this was not possible with females so the male physician had to rely on oral history and take inference from patient's illness presentation. This according to the doctor was not a complete scientific procedure and the doctors had to rely on incomplete diagnosis to treat the patient's problem.

**Table 3: Congruency between Patient & Doctor on Communication**

Communication	Doctor A	Doctor B	Doctor C	Sadia	Shaheela	Baseerat	Najma
Communication between female patients and male doctor does not happen candidly. The details of medicine use are usually communicated by the LHV.	Female patients go directly to the LHV. Although this not in her domain to prescribe medicine or antibiotics.	Patients with more age, education are easy to communicate with than the less educated and poor patients	I prefer going with my sister-in-law who communicates the problem with the doctor, as I feel too shy and embarrassed to talk.	I prefer to accompany my mother-in-law because communication with the male doctor is difficult. So the older lady communicates on her behalf.	The doctor only checked the previous reports and prescribed the medicine without investigating the illness himself.	The doctor also refrains from detail history taking and simply resorts to giving oral medication without thorough investigation.	

Table 3: Congruency between Patient & Doctor on Communication

Table 3 shows communication problems faced by the female patients and male doctors while interacting with each other. Female patients feel hesitant in divulging about their female health issues like likorea, UTI, kidney pain etc. Similarly the doctor also remains sensitive towards the modesty needs of his patients and tries not to go into detailed examination and investigation. The doctors mostly refer to a culturally appropriate word like *Beemari* - an umbrella term for illness but meaning periods, pregnancy or missed periods here, before prescribing medicine and injections. No details any precautions required, special dosage etc. were communicated with the patient. Hence the simple *modus operandi* would be to prescribe medicine, antibiotic or administer injection with minimal of investigation, to avoid awkwardness on part of the female patient and the doctor too.

## Discussion

Communication problems were faced by the female patients during their interaction with male doctors. Mostly these patients visited male doctor for general ailments, children care and for few minor female health issues. Communication pattern varied in the doctor-patient dyad when there was gender discordancy. One of the more prominent issues that surfaced through this study was the presentation of illness by the female patient and management of the problem and treatment communicated by the male doctor. On both the sides, it was observed that minimal of explanation was given about the prevailing health problem. Communication of female patients was strongly influenced by the underlying cultural factors, modesty and religiosity issues. All these factors in combination with low social status and literacy rate of the female patients created barrier in their free and comfortable interaction with male doctor. Similarly, the doctors also felt compelled by the prevailing cultural norms and tried to remain discreet in their handling of female health issues. These doctors nevertheless advocated for consulting a trained, professional physician by female patients rather than going to in-formal female and male medical practitioners. In case of diagnosis, treatment and management of the problem, the male doctors at BHU and the village quasi-doctors refrained from probing in details about female health problems like in likorea, UTI, kidney pain or abdominal pain. They were also compelled to abstain from physical examination and thorough investigation in case of gastrointestinal pain, before prescribing medicine.

To rule out the prevalence of existing pregnancy, the male doctor would generally ask about the marital status, children of the patient and then refer to '*beemari*' before prescribing medicine or administering injection. Similarly no explanation on the method of use of medicine or any abstention required was communicated with female patients by the male doctors. Absence of clear understanding and communication interfere with better compliance by the patient and proper use of drugs, thereby reducing its efficacy and overall desired health goal is not reached.

### 4.3 Preference for Female Physicians

All patients unanimously agreed upon the need for a female physician at the BHU. Patient Saida stated clearly about her preference:

*Female doctor is better because I can tell her all my problems whether general, children care or female issues openly without hesitation*

If female patients are dealt by female doctors, all different type of medications and treatment regime could be easily discussed and prescribed by the doctor and detail medical history could be taken for effective diagnosis. This kind of complete problem presentation by the female patients to the female doctor and detail history taking by the doctor would have positive effect on the overall treatment plan; ensure better compliance and understanding by the female patient and eventual better health delivery.

When male doctors were enquired about the option of having a female doctor at BHU and how it would made the difference all of them agreed on having a female physician would by far be a better choice than having a male doctor. As one of the doctors, Dr. Islam, who had many years of experience at BHU concluded:

*If there is a choice between a male doctor and a female one, I would recommend a female doctor. A female physician is versatile in the sense that they are able to check everybody irrespective of gender. She could check the male patients and female patients very easily. So if the option is for one doctor at BHU then it should be a female doctor.*

Another patient Taj Bibi said that being an unmarried woman she felt comfortable with female doctor. Therefore she preferred a female physician for unmarried and young girls for whom it is difficult to consult a male doctor or share health problems openly.

Sadia, a female respondent said:

*Female physician is better because all kinds of problems whether general, child's health concerns and female health issues of all types could easily and openly be discussed with her without any hesitation.*

Another advantage of having a female physician in primary care is that female guardian while visiting the doctor for their children could also discuss their health concerns and get an understanding of the issue. Since modesty and chastity are the most valued possession of females in our culture, the presence of female doctors' in primary care becomes a paramount need.

According to one doctor at BHU, Dr. Islam

*Female physician are considered omnicompetent as they can manage and handle all male and female problems skilfully without hesitation in communication.*

Similarly the patients also feel completely at ease, open and comfortable in the company of female doctor. The former is able to ask more questions social and medical and take detailed history while the latter also indulge in giving all necessary details and even some more. This kind of detailed comprehensive and in-depth communication has positive effect on the overall satisfaction, compliance and health of the patient.

**Table 4: Congruency between Patient & Doctor on Physician Preference**

<b>Preference for Female Physician</b>					
<b>Doctor A</b>	<b>Doctor B</b>	<b>Taj Bibi</b>	<b>Sadia</b>	<b>Nadia</b>	<b>Shaheela</b>
Female doctors are omni-competent i.e. they can handle female patients as well as male patients without any hesitation or cultural inhibition	Female doctor is far better because she can manage all female patients and their problems without hesitation.	As an unmarried woman I feel reluctant to see a male doctor or share my health problems openly with him.	With male doctor we cannot reveal everything. So for female issues or advance problems a female physician would be opted for.	Female physicians are preferred over male in all aspects. We could discuss our issues easily.	Due to modesty and reservation only a female physician is preferred to be consulted

*Table 4: Congruency between Patient & Doctor on Physician Preference*

The table above shows, all female patients and male doctors concurred upon having a female general physician or a gynaecologist at primary health level BHU. Female doctors are omni-competent who can easily check female patients' problem as well as male patients. The patients also felt the dire need for female physician as that would dissipate the problem of communicating their health issues of gynaecological nature with the doctor.

## **Discussion**

There was a complete, unequivocal and unanimous agreement on having a female physician by the female patients as well as medical practitioners at the BHU, as the most preferred choice. The doctors concurred that female general physician are omn-competent professionals who are trained and socially conditioned to handle male patients and female patients both well. The male patients feel no hesitation to consult a female doctor for their health issues and it is a blessing for rural female patients to have a female doctor in their vicinity with whom they could share their distress openly.

The absence of qualified female physician at the BHU impels female patients to make multiple visits to multiple health practitioners for the treatment of same problem that could be treated at BHU. In addition, this practice of 'doctor-shopping' does not entail any better quality access or better equity aspects of health. It also does not predict better health care accessible and available to all. With female doctors at the facility, the female patients are not only able to consult for themselves whenever required but also have the opportunity to consult for themselves while taking their child to the doctor. This aspect would have positive fallouts on the overall health condition of the female patients, child care and better understanding and knowledge about themselves.

## CHAPTER - 5

### Conclusion & Recommendation

#### 5.1 Conclusion

The health-seeking behaviour, in conclusion, is strongly affected by sociocultural and religious ideas of the people utilizing it. In order to bring about the expected and desired level improvement in the health status of people, our health policies need to be informed with the health seeking and utilization behaviour of people. It needs to recognize the drivers of health-seeking behaviours through expanding the research into various geographical areas, gender-wise study and different medical conditions that have been overlooked.

After integrating the data, findings and discussion on the analysis, several conclusions on culture competence and patient-physician interaction are suggested.

Firstly, female patients face considerable amount of cultural inhibition in form of *purdah* - modesty while consulting male doctors especially for female health issues. They feel reluctant and hesitant in discussing or explaining issues like pregnancy, urinary tract infection and vaginal discharge with male physicians, causing high unmet need. Many even endanger their lives by subsequently consulting unskilled health practitioners. The profound influence of culture on doctor-patient relationship has been a topic of much debate in various studies (Uskul & Ahmad, 2003; Bensing, 1993; Gray, 1982). Culture and religion are two inextricable entities which greatly influence the attitudes, beliefs and practices related to health care. If religious and cultural needs of the patients are overlooked or not accommodated for as noted by Hasnain (2011), there is bound to be considerable challenges for both the doctor and the patient in managing and treating health problems, which subsequently translate into higher cost of health care and eventual slow health improvement.

Secondly, the distance aspect separating patients from their nearest health facility available is an imminent barrier, particularly in rural areas, which evolved through this study. According to Shaikh & Hatcher, (2007) the nearest and most easily available health provider in the rural areas would be a non-formal medical practitioner – mostly a village male doctor observed in this study, who is consulted primarily for the low cost, easy accessibility, family approval and for the level of confidence and trust attained by him because of his long years of work experience and presence in that area. Hence, household economics has major underpinning in limiting the choice and behaviour of female patients' seeking health care. Women's inability to travel alone as and when they wish is viewed as an important obstacle to improving their health by Moazzam (2008). Moazzam (2008) further elaborates that the absence of female physician in primary care makes these otherwise accessible health facilities socially unacceptable and inaccessible and deprive women of their basic human right to equality of treatment and dignity. The female patients, in the study were observed to either consult an LHV at BHU in their proximity or where BHU was not accessible, they were compelled to seek health care from alternative health care providers - like village doctor, female local health practitioners and private clinics and some formal ones in public sector hospitals. In both the cases it was observed that female patients visited untrained and unskilled staff for health care. Thus, the opportunity to improve health condition is lost on patients due to untrained practitioners and low quality service in the non-formal health care sector (Shaikh & Hatcher, 2007).

Third, medical consultation requires doctors to extract sufficient information upon which they could carry out proper diagnosis, treatment and management of the problem (Malterud, 2009). The female patients however, were found hesitant and reluctant to disclose openly to male physician about their health issues. They tried to offer minimal of explanation, usually in form of a single word and the male doctor picking a cue from that formed his total diagnosis and treatment based on that hint. However, research indicates to the contrary that during doctor- patient interaction it is essential for the doctor to understand patient's concerns, her presentation of illness and expectations. According to Malterud (2009) symptoms perceived and presented by the patient form critical basic information in the diagnostic process (Bentsen, 1986). Malterud further explains that the

doctor-patient relation is to a great extent influenced by status and gender congruence between the two participants. Taking it one step further, Hasnain (2011) highlights positive correlation between effective communication and improved health status through optimal patient satisfaction, treatment compliance and positive treatment outcomes. On the contrary, if there is perceived lack of sensitivity towards religious and cultural beliefs, patients show reluctance in seeking health care, might avoid seeing a physician until advanced stages of illness and ultimately ensuing higher costs and poorer health outcome Husnain (2011).

On the effects of physician's gender on patient-doctor relation, patient-centered approach and communication, several studies have been recorded (Uskul & Ahmad, 2003; Bensing et al., 1993; Gray, 1982 & Sawyer, 1979). Roter (1991), on duration of time spent by female physician with female patients particularly during the history-taking part, positive communication, rapport building, more question asking by engaging in biomedical, psychosocial and psychosomatic information gathering. Walton (1968) and Cartwright (1967) on female physician's sensitivity towards patients suffering, relationship building and understanding. Henley (1979), Homans (1980) and Haar, et al (1975) on favouring female physicians by female patients because of their gentler disposition and sharing similar physiology. Hence, all the studies converge upon the same fact that female physicians are more competent in extracting better information from her patients through positive and skilful communication, creating congenial relationship and benefitting the patients through better compliance and health outcomes.

Fourth, the study indicates that there was complete congruence and similarity in the views of medical provider and female patients on having a female physician in primary care centers. Patient's choice of doctor's gender is said to be an important factor and a sensitive issue for Asian women. As Ahmed (1980) points out that Asian women are used to having only female obstetrics and gynaecologists in Pakistan and India. He further elaborates that the specific preference for female doctors by female patients essentially lies in female 'modesty' as the most prized possession in Pakistani and Indian culture. (Ahmed, 1980 quoted from Mann, 1989; Hinley, 1979; Homans 1980; Khan 1979, Currer 1983 & Homans 1980: 330). Sheikh (2007) points in the same direction that women in

our traditional society need to seek permission from the male head of the family to visit health services. Whereas paucity of female physicians restricts females from seeking timely and appropriate health services and majority resort to visiting alternative or non-formal practitioners thus jeopardizing their health status.

It is hence concluded that data findings gleaned through this study could direct further research on better addressing the socio-cultural barriers faced by patients and providers both, in order to ensure better and quality care for female generation as well as the future generations.

### INDIGENOUS MODEL OF INTERACTION BETWEEN MALE DOCTORS AND FEMALE PATIENTS

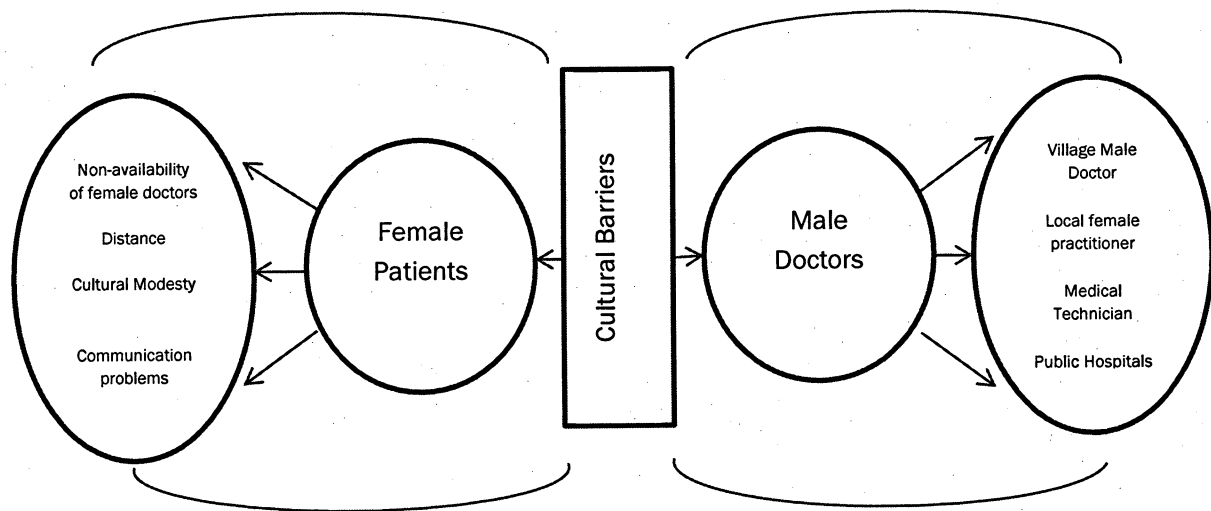


Figure 2: Indigenous Model of Interaction between Male Doctors and Female Patients

#### 5.1.1 Formulation of an Indigenous Model

Based on the detailed qualitative analysis undertaken in the study, an indigenous model is postulated. In comparison to the earlier conceptual framework hypothesized before

fieldwork, some new aspects emerged during the field study which are added to the model.

Female patient and male doctor dyad is the most common topic of research study for anthropologists. Setting this dyad against the traditional framework of our society, I have attempted to study the cultural barriers faced by the female patients during their interaction with male doctors in primary health care centers. According to the diagram the interaction between doctor and patient is greatly influenced by socio-cultural barriers. These barriers subsequently impede health seeking and utilization behaviour of the female patients. Female patients' decision to visit a doctor involves several impending factors that could be classified into social, religious and cultural barriers. Female patients hailing from rural areas have low social status, higher illiteracy rates, poverty, having subjugated position in family, facing poor water and sanitation facilities. The patients need to seek permission of the family members and are required to accompany them for visiting a doctor. All these factors take toll on the health condition and health seeking behaviour of the women (Shaikh, 2007) & (Pakistan Gender Profile, 2008).

According to the schema, on the left hand side various factors such as non-availability of female doctors, distance, communication barrier etc. are compounded by the cultural factor and necessitate female patients to utilize several different health facilities available in formal and formal sector. First of all, non-availability of female physician in primary care is the most important dilemma faced by the patients. Infact, this aspect is at the root of all ensuing challenges faced by the female patients. When a female patient visits health center in rural areas, the absence of female doctor redirects her to multiple other alternative health practitioners both formal and non-formal. Goto, et al (2015) terms this practice as 'doctor-shopping'. When the expectations, concerns and prognosis of the patient do not match the diagnosis and management by the doctor, patients consult several health care providers. However, multiple visits to several doctors for the treatment of same problem treatable at primary care do not ensure better quality service.

Secondly, it was observed in the study that cultural barriers like modesty and religious beliefs played an important role in shaping the health seeking attitudes of the female patients. Due to purdah and traditional norms, these patients preferred to consult only a female health provider or alternatively one who is nearest to the patient's house. Distance between the health facility and patient seeking primary care emerged as a distinct factor which either obliged the patient to refrain from seeking health care at all or seek alternative avenues with low cost with low quality service and untrained staff.

Similarly, when the patient visited village male doctor due to his easy accessibility and low cost, the female patient felt reluctant mostly to share their health issues openly. Lack of proper communication during history taking session by the female patient greatly impedes correct diagnosis and management process reached by the doctor (Goto, et al, 2015; Shaikh, 2007 & Husnain 2011). All these factors of religious beliefs, modesty, distance and mobility, communication barrier had a cumulative effect, ensuing poor recovery rates and health condition of the patients.

On the other side of the spectrum, male doctors available at the BHU were consulted by the female patients mostly for their children and only rarely for themselves. In case of severe illness like abdominal pain, dysentery, UTI etc. the patient accompanied by the LHV would be referred to the male doctor. The doctor despite being a trained professional feels compelled by the prevailing cultural norms to keep the investigation with female patient brief and avoid physical examination of the body or abdomen area etc. This in turn affects the proper diagnosis process reached by the doctor, understanding of the problem and thereby management of the illness.

In the same vain, communication barrier faced by the male doctor at the BHU or the village doctor restrains them from giving full details of the prognosis, details of medicine use and method and any precautions to be taken. As a result the situation is compromised between unmet needs of the female patients and unsatisfactory treatment and management provided by the doctor.

During the course of my research study and fieldwork, certain explicit indicators were revealed that had not been previously discussed in the extensive literature review undertaken on the subject:

The influential role of LHV's discovered in the absence of female doctors at BHUs. The LHV's were able to fill the proxy for female physicians by treating female patients for wide array of health problems ranging from general ailments and child care to all gynaecological issues treatable at BHU. Another interesting fact revealed was the secondary role played by the LHV as a 'private female physician' in her local area of residence to treat local female patients and carry out profitable private practice on the side lines, without being a certified, registered trained doctor.

Secondly, the LHV's role in the BHU was rendered so effective and dynamic that even in the presence of the male physician; the female patients consulted the LHV. This fact was also acknowledged by the doctors, making their role less effective or even redundant.

Third remarkable point of departure from the literature review was the inclination of female patients to visit 'male' doctor from the village for their health problems – general issues and minor female issues, yet avoid visiting a male doctor at the BHU. The reasons attributable to this fact were proximity, easy accessibility and more important the influential position commanded by the village doctor as a trust-worthy and credible person. These opinions were not shared with the male doctor at BHU.

Finally, cultural aspect as an over-abiding factor influencing health seeking and utilization behaviour of female patients has emerged as an established fact in previous researches. However, in those studies reference is given to female patients being affected by socio-cultural norms avoiding male physician for advance female problems or reproductive health. However, it was gleaned through this study that even for general ailments like fever, infection the female patients felt reluctant and would consult the LHV instead. The reason for this marked difference of views is the cultural difference and sensitivity related to one specific region.

In the final analysis it is concluded that in order to overcome these inhibiting cultural barriers and more importantly to ensure better quality care and better social accessibility to health care for female patients, availability of female physician at primary care is paramount.

## 5.2 Recommendations

This research study highlights the importance of cultural competence and sensitivity to the socio-cultural needs of the female patients in doctor-patient relation which are frequently overlooked in the health interventions and services for the underprivileged and minority patients.

Ideally, availability of female physicians in every primary care unit BHU is imperative. Basic Health Units were established with the sole objective of serving as first line defence against general ailments and safeguarding the health of mother and children, by making the primary care network easily accessible for them to ensure timely assistance from qualified medical practitioners.

However, to what extent are the primary units socially and physically accessible to female population in rural areas and to what extent are the health care needs of the female patients met through these formal health care units were determined through this study.

1. Majority of the patients visiting the BHU are females who visit these facilities for their children or for themselves. For general ailments they would consult the male physician in the facility however, for all other female problems, the LHV is consulted. It is hence strongly recommended that one female doctor should be made available at all BHUs replacing the male doctor. The female physician has the capacity to check both male and female patients easily and it is also culturally suitable and more acceptable for both the genders.
2. The distance between patient and nearest health care unit is a crucial factor. Due to greater distance of some BHUs from the patient's residence coupled with non-availability of female doctors, it makes these otherwise accessible centers least acceptable socially. Health care is sought from alternative non formal practitioners. The second suggestion hence is to setup BHUs at more proximate geographic location along with having a female physician on job so that female patients can have timely utilization of services from qualified and trained staff.

3. Availability of female physician at BHUs is an ideal situation and best response for overcoming the low utilization of health services at these units by female patients. However, if female doctors could not be made available at each unit, the alternative option is to educate and inform the female population in rural area about the necessity to discuss their health issues openly with the doctor available, irrespective of physician gender. The mass media through newspapers, radio and television should play its role in conveying the message, educating and informing the masses on utilizing health services at BHU. Similarly through informal channels like opinion leaders in the community, teachers, family elders, religious scholars, LHVs and LHWs and etc. women from uneducated and less privileged background should be sensitized towards acquiring health care services from the physician available at the BHU instead of going to alternative non-formal sector.
4. Health care delayed is health denied and in some cases endangering life. Regular monitoring visits are the needed, by the Directorate of Health to analyse the past records of all BHUs for cases of patient complication leading to eventual death because of non-availability of female doctor, appropriate medical staff or medical equipment. Such Units and areas should be marked and served with improved healthcare facilities immediately without any further delay.
5. Further it is also suggested that satellite female doctors should be provided to the BHUs which are working without female physicians. The number of days in the week should be specified and announced in the areas so that local female patients could get easy access to better health care.
6. To encourage female doctors to serve at the primary health facilities better financial incentives, packages and conducive working environment should be offered to encourage more female physicians and upcoming female medical students to serve at various Units without hesitation.

7. Sensitisation of male doctors is required towards better understanding of modesty requirements of the patients. Trainings in communication skills should be imparted to doctors to equip them with skilful ways of information sharing and gathering from female patients in socially stigmatized diseases. Better communication between doctor and patient could foster better cooperation, understating and sharing of valid information on part of patients and allowing doctor to conduct required physical examination and thorough investigation without making the patient uncomfortable. This would ensure proper diagnosis, better management of the problem and compliance with the treatment improving overall health care system

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## **APPENDIX 1**

### **Interview Guide for Female Patients**

Q1. Reasons for visiting the facility?

Q2. Who did you consult?

Q3. In case of accompanying a child for consultation, have you ever come here for self?

- a) NO
- b) YES,

Q4. If Yes, for what reasons:

- i. General ailments
- ii. Minor Female problems — likorea, dysmenorrhea, contraceptives or UTI.
- iii. Advance Female problems – pregnancy, heavy bleeding, breech, missed abortion and serious reproductive health issue etc.
- iv. For all problems

Q5. Who did you consult for the problem?

Q6. Who would you prefer to go to?

Q7. Are you satisfied with the treatment provided by the practitioner –Male doctor or female LHV?

#### **During the Visit:**

Q8. Are you visiting alone or do you visit health center alone or accompanied by kids, family member or neighbour?

Q9. Any objections from the family on visiting this facility or any other facility? (first line blood relative or family members) – spouse, mother in law, father in law, brother, sister or mother etc.

Q10. Your preferences for doctor?

General Health issues – male doctor / female doctor

Gynae issues – minor or advance – male doctor / female doctor

Communication Barrier:

Q11. While consulting a Male practitioner at health center, are you able to explain your problem explicitly and clearly?

- a) General ailments – Y / N
- b) Female specific issues – Y / N

If No then where do you go?

Management or Treatment of the Problem:

Q12. While consulting male doctor, does the male doctor or practitioner ask you about female health issues easily clearly and in detail? Or modesty is observed? E.g. in case of likorea – color, smell, periods etc. are asked about?

Socioeconomic Indicators:

- i) Age
- ii) Education – work – income, if any?
- iii) Marital Status

- iv) Children
- v) Husband's job – wage level
- vi) Family structure – nucleus, joint/ combined, extended etc

### **Interview Guide for Male Doctors**

Q1. Around how many female visitors come to you – with or without children

Q2. Reasons for consulting you – for self or children?

- i) General ailments - flu, cough, fever, infection etc.
- ii) Female specific issues – general / advance

Q3. If female specific problems are not brought to you, then who do they consult?

- i) Female doctor / medical staff
- ii) Male doctor / medical staff

Q4. Do they come alone or come accompanied?

Q5. Does the family member accompanying talk to you on patients' behalf? If yes, reason.

Management of the problem:

Q6. While talking to the female patient about her female health issues, are you able to investigate her easily and thoroughly (like a female doctor would)?

Q7. Are you able to explain to her clearly, management and treatment of the problem and any precautionary measures taken?

Q8. If not, only modestly, are there chances of poor or less compliance or mistreatment?

Q9. Are female patients able to explain their health issues especially female specific openly with you or just in brief way only – using key words only?

Q10. In your opinion, is female doctor better option for BHU than a male doctor and how?

**APPENDIX II**

**Table 5: Reasons for Visiting Multiple Health Centers by Female Patients**

Female Pts	BHU	Consulted & Treatment	Village Doctor	Treatment	Local Female Practitioners, Pvt. Clinics, Secondary & Tertiary level Govt. Health Centers
1	BCG Injection to the baby, only for child	MT administered the injection	1) Self - general ailments, flu, fever & cough etc.; 2) minor female health issues, UTI, ikorea, kidney pain etc. & for children's illness	Mostly prescribes oral medicine and injection	1) Government hospital for advance reproductive health issues - pregnancy, abortion etc. 2) Local area female doctor for ultrasound test and checkup etc.
2	Baby's vaccination	MT	1) For general ailments, 2) minor female problems, ikorea etc. accompanied by sister in law 3) Children's illness	Prescribes oral medicine & injection without detail history or examination	1) Private clinics having female doctors for advance reproductive issues, goes to
3	Accompanying for baby's vaccination	MT	1) For general health issues, 2) minor female problems, ikorea, dysmenorrhea etc.	Prescribes oral medicine and injection	Unmarried therefore reproductive health issues not experienced. Would prefer to go to private clinic with female physician in future
4	Baby's vaccination	MT	1) For general ailments 2) female health issues	Oral medicine and injecting checking previous reports	1) Govt. & tertiary hospitals for female health issues & reproductive health
5	Baby's	MT	1) For general health	Oral medicine	1) Local female practitioner in

Female Pts	BHU	Consulted & Treatment	Village Doctor	Treatment	Local Female Practitioners, Pvt. Clinics, Secondary & Tertiary level Govt. Health Centers
10	To acquire free medicine - paracetamol, supplements and for stomach worms	LHV prescribes all medicines - pain killers, antibiotics and administers injections	Male village doctor consulted only rarely for general problems, consults LHV at BHU mostly	None	Only female doctor consulted for all female health problems major & minor
11	General checkup and free medicine	LHV prescribes all medicines - pain killers, antibiotics and administers injections	No male village doctor consulted	None	For general and female health problems mostly consults the LHV at BHU or other female doctors.

Table 5: Reasons for Visiting Multiple Health Centers by Female Patients

Table 5 is a comprehensive and concise presentation of various reasons given by the female patients for visiting multiple health facilities. First column shows the female patients visiting BHU mostly for baby's vaccination and some for themselves for general ailments and minor female issues that are treatable at the BHU.

The treatment at BHU was carried out by the MT for baby's vaccination and by LHV for other female health issues. Secondly, due to the proximity of the village doctor to the patients' residence, many female patients showed proclivity towards going to the male pseudo-doctor in their locality for consulting of all general ailments and even minor female health problems like likorea, UTI, dysmenorrhea, kidney pain etc. The standard modus operandi for the village practitioner is to prescribe oral medicine – pain killer or antibiotics or administer injections without full investigation of the problem, examination and rather depending on the previous medical reports.

For all advance and serious female health cases – gynaecological and reproductive health, the time honoured tradition of consulting female physicians was strictly followed. It was observed that female patients had to visit multiple health facilities such as local female practitioners, private clinics and secondary or tertiary government hospitals for treatment of the same health issue. Hence, the non-availability of a female physician at primary health center in local area lead most of the patients to go ‘doctor-shopping’ incurring higher expenditure, time and at the cost of failing health, for the problems treatable at BHU.

