Connecting gender and community-based social networks to explore health service access and use in Negros Occidental, Philippines: A qualitative study

*Kathy Luu[1] MSc(c), Lincoln Lau[1,2,3] PhD, Jennifer Liu[1,4] PhD, Warren Dodd[1] PhD

[1]School of Public Health and Health Systems, University of Waterloo, Canada; [2]International Care Ministries, Philippines; [3]Dalla Lana School of Public Health, University of Toronto, Canada; [4]Department of Anthropology, University of Waterloo, Canada.

BACKGROUND

In low- and middle-income countries (LMICs), social networks, social support, and capital are structural and intermediate determinants of health[1]. They are integral to information sharing about health care access and use[2,3,4].

Social capital produces various forms of social support (e.g., financial and childcare support) that can be valuable during stressful events[5,6]. It is important to consider how these social networks are gendered.

Life course and biological stages and socioeconomic status (SES) may negatively impact young women's health experiences in some LMICs, especially, reproductive and maternal health outcomes[7,8].

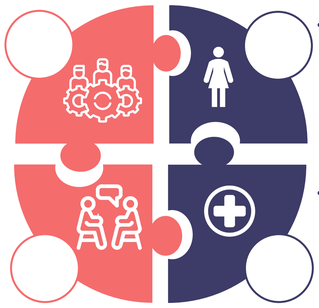
Several studies demonstrate the importance of social support and capital, on reproductive and maternal health outcomes[9,10]. There is a need to understand how social networks, change throughout women's lifespan, and how networks impact women's access to health care services in LMICs.

Despite the efforts to enhance Universal Health Coverage (UHC) in the Philippines, there is a lack of exploration of the specific factors that either facilitate or hinder health care access and use throughout the lifespan among Filipina women experiencing poverty .

The purpose of this research study was to 1) describe health care access and use among women experiencing extreme poverty in low resource settings, and 2) explore how gender and social networks interacted and shaped health care access among young, middle-aged, and older adult women experiencing poverty in Negros Occidental, Philippines.

METHODS

- We conducted semi-structured interviews and questionnaires in seven urban and peri-urban barangays in and around Bacolod City, Negros Occidental.
- We partnered with International Care Ministries (ICM), a local Philippine-based non-governmental organization (NGO) to help with coordination and translation.
- In total we conducted 35 interviews and questionnaires in either Ilonggo or English with health care beneficiaries and 15 health care providers.



- To analyze the questionnaires we used descriptive statistical analysis.
- To analyze the health care beneficiaries interviews we used the Patient-Centred Access to Health Care (PCAHC) framework[11], and elements from the Life Course Theory (LCT)[12] to conduct a deductive and inductive thematic analysis[13].
- For the health care providers interviews, an inductive thematic approach was employed to analyze the common sentiments expressed by the participants[14].

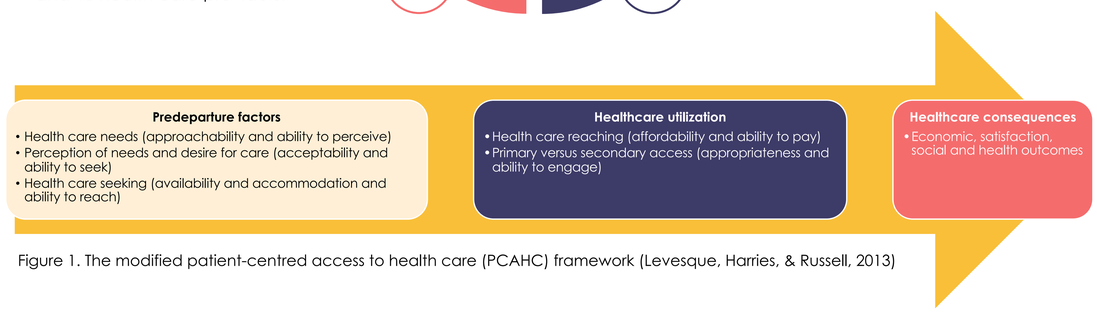


Figure 1. The modified patient-centred access to health care (PCAHC) framework (Levesque, Harries, & Russell, 2013)

RESULTS

- 35 health care beneficiaries were interviewed from 7 barangays. Interviewees were all women between 18-75 years old.
  - **18-30 years old (n=10)**, **31-45 years old (n=11)**, **46 -59 years old (n=9)**, **and 60+ years old(n=5)**
- The majority of the health care beneficiary participants were married, at-home parents, and had achieved a secondary school- or college-level-education.
- 24 health care beneficiary participants (68.6%) reported that they were PhilHealth beneficiaries
- Almost all women obtained a primary school education. Women younger than 30 years old all had a secondary school- or college-level education.
- Overall, most women had 0-10 members in their households. The majority of women between 31-59 years old had 6-10 members, whereas most women in the youngest and oldest age groups had 0-5 members.
- In addition to the 35 health care beneficiaries, we interviewed 15 health care providers from the same communities (e.g., barangay health workers (BHWs), barangay nutritional scholars (BNSs), midwives, nurses, doctors, and barangay health officials).

1) Characterizing predeparture access factors: Understanding health care decision making and challenges among women

- Health care decisions were heavily influenced by perceptions of the severity of their health concerns, trust in the healthcare workers and facilities, and the availability of financial resources.
- Barriers expressed among participants included the lack of financial resources to cover transportation costs, difficulties obtaining transportation, and opportunity costs.
- Younger women prioritized the health of their children
  - Reported smaller perceived networks and difficulties seeking childcare and financial support to cover indirect costs compared to women in the other three age cohorts

2) Identifying health utilization factors: Barriers and challenges to engaging in treatment and care among women

- Women commonly reported the drawbacks in technical (e.g., long wait times) and interpersonal quality of health professionals (e.g., discrimination), lack of staff and resources, the burden of the direct costs of diagnostic tests and treatment, and difficulties acquiring health insurance coverage.
- Most women from the three oldest age cohorts connected with governmental agencies and neighbours, and had financial support from their children to cover their medical care costs.

3) Characterizing the health care consequences

- Almost all women were satisfied with their health care experiences, however all preferred private over public care, and experienced financial (e.g., unpaid loans and debt) and social outcomes (e.g., increased social connectedness).
- Loans profoundly impact women's abilities to obtain basic needs, such as food. Some women relied on food donations from the sari-sari store because they did not have the funds to purchase groceries.
- Older women leveraged their connections (e.g., neighbours and politicians) to gain information about donation and health subsidy opportunities and to manage their loans and costs.

4) Health care providers perception of access barriers, challenges providing services, and responsiveness to the needs of their patients

- Outreach work was widely conducted in these communities as BHWs expressed that most of their responsibilities (e.g. performing check-ups) centred in their catchment areas.
  - BHWs' noted that the physical distance, lack of financial resources for transportation, and materials were challenges.
- Doctors, midwives, and nurses stated that they were connected to local NGOs, and provided community members with medical attention.
  - Some doctors, nurses, and barangay officials stated that they experienced shortages in staff members and medical resources, and had limited influence on the barangay's health care funding decisions.

DISCUSSION AND CONCLUSION

Findings indicate that women may have varying degrees of social support from their networks throughout their lifespan that can contribute to the availability of social and financial resources, which may facilitate or restrict their access to health care services.

Community health workers (CHWs) in LMICs are responsible for connecting individuals to available public health services and providing information through their outreach work[15,16]. Support outside of the formal health care sector may be investigated to understand how these networks can facilitate access to care.

UHC does not consider indirect and opportunity costs incurred at the pre-departure stages (e.g., transportation and missed work) as out-of-pocket expenditures on health care services, however, these financial barriers remain an obstacle for individuals in LMICs.

Exploring the intersecting influences of age and gender can reveal the compounding disadvantages that existed among women. Other individual- and structural- factors should be further investigated to maximize the effectiveness of policies that target the most hard-to-reach segments of the population.

REFERENCES

1. Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva, World Health Organization, 2010. Retrieved from https://www.who.int/social_determinants/corner/SDHDP2.pdf?ua=1
2. Hou, Z., Lin, S., & Zhang, D. (2017). Social capital, neighbourhood characteristics and utilisation of local public health services among domestic migrants in China: a cross-sectional study. BMJ Open, 7(8), e014224.
3. Story, W. T. (2013). Social capital and health in the least developed countries: a critical review of the literature and implications for a future research agenda. Global Public Health, 8(9), 983-999.
4. Fadlallah, R., El-Jardali, F., Hemadi, N., Morsi, R. Z., Samra, C. A. A., Ahmad, A., ... & Akl, E. (2018). Barriers and facilitators to implementation, uptake and sustainability of community-based health insurance schemes in low-and middle-income countries: a systematic review. International Journal for Equity in Health, 17(1), 13.
5. Sun, H., Hartarska, V., Zhang, L., & Nadolnyak, D. (2018). The influence of social capital on farm household's borrowing behavior in Rural China. Sustainability, 10(12), 4361.
6. Adjaye-Gbewonyo, D., Rebok, G. W., Gross, A. L., Gallo, J. J., & Underwood, C. R. (2019). Assessing urban-rural differences in the relationship between social capital and depression among Ghanaian and South African older adults. PloS One, 14(6), e0218620.
7. Mishra, G. D., Hockey, R., & Dobson, A. J. (2014). A comparison of SF-36 summary measures of physical and mental health for women across the life course. Quality of Life Research, 23(5), 1515-1521.
8. Dev, R., Kohler, P., Feder, M., Unger, J. A., Woods, N. F., & Drake, A. L. (2019). A systematic review and meta-analysis of postpartum contraceptive use among women in low-and middle-income countries. Reproductive health, 16(1), 154.
9. Chiao, C., Yi, C. C., & Ksobiech, K. (2012). Community effects on pregnancy intention among cohabiting women in the Philippines: implications for maternal and child health. Maternal and Child Health Journal, 16(6), 1293-1303.
10. Pillai, V. K., & Maleku, A. (2013). Reproductive health and social development in developing countries: Changes and interrelationships. The British Journal of Social Work, 45(3), 842-860.
11. Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health, 12, 18.
12. Elder Jr, G. H. (1994). Time, human agency, and social change: Perspectives on the life course. Social Psychology Quarterly, 4-15.
13. Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis : A Hybrid Approach of Inductive and Deductive Coding and Theme Development. International Journal of Qualitative Methods, 80-92.
14. Boyatzis, R. (1998). Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage.
15. Jeet, G., Thakur, J. S., Prinja, S., & Singh, M. (2017). Community health workers for non-communicable diseases prevention and control in developing countries: evidence and implications. PloS One, 12(7), e0180640.
16. Khetan, A. K., Purushothaman, R., Chami, T., Hejjaji, V., Mohan, S. K. M., Josephson, R. A., & Webel, A. R. (2017). The effectiveness of community health workers for CVD prevention in LMIC. Global Heart, 12(3), 233-243.

If you have comments or questions about the study, please contact Kathy Luu at Kathy.luu@uwaterloo.ca.