STRENGHENING INFORMAL HEALTHCARE DELIVERY: GENDER PERSPECTIVES

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ABSTRACT

This paper presents a case for factoring in gender perspectives in initiatives intended to strengthen informal rural healthcare delivery systems by way of improved access with a view to entrenching rural livelihoods. Given that increasingly, the informal health sector is shouldering the healthcare delivery service burden, the argument is that in order to enhance rural healthcare system performance, it is important to strengthen informal healthcare services – and one way of doing that is to improve informal healthcare practitioners' access to homesteads [where their patients live] and health facilities. This can be done buy providing adequate transportation infrastructure and services as well as communication in rural communities. However, it is of interest to note that the rural informal healthcare system is predominantly serviced by women, which provides the rationale for deliberately focusing the intervention options referred to above on women. With the help of a case study, this paper highlights the role and scope of home-based care to decentralised healthcare especially in rural areas in fighting disease, poverty, isolation and deprivation. It will profile the importance of transportation infrastructure and services as well as communication in facilitating informal healthcare service delivery. One strand of thought that runs through the paper is that the generation of gender sensitive intervention options that relieve the informal healthcare practitioners' "pain points" [which are largely access oriented] when providing services is crucial to sustaining and even improving healthcare service delivery.

Keywords
Informal healthcare, gender, mobility, access, communication, health delivery systems, home-based care

1. INTRODUCTION

1.1 Background

Transport plays a pivotal role in the effective and efficient delivery of health care in rural South Africa (Mashiri et al, 2007). The adequate provision of and access to healthcare services that are necessary preconditions for meeting the Millennium Development Goals (MDGs) for Health by 2015[1] depend on complex inter-sectoral linkages to which transport makes essential contributions. The transport sector affects the availability of both preventive and emergency care, potentially impacting service delivery rates, for example, it is essential for the distribution of drugs, blood and other supplies to health facilities, enables the timely transfer of patients between health facilities and to the different levels of care of health referral systems. Efficient transport systems also facilitate access by health

[1] International development targets intended to slash a host of global ills by 2015

workers to often sparsely populated rural areas, as well as the necessary monitoring and supervision of heath services and initiatives (World Bank, 2004).

In a review of evidence relating to the role of transport in reducing both child mortality (MDG4) and maternal mortality (MDG5), the World Bank's Transport and Social Responsibility Thematic Group concluded that considerable time is spent by women and their families waiting for transportation and travelling to a distant health facility especially in rural areas (World Bank, 2004). In addition, poor roads, too few vehicles and high transportation costs are major causes of delay in deciding to seek and reaching emergency healthcare. As indicated elsewhere in this article, women tend to bear the brunt of this burden more than their male counterparts, particularly given that sseventy percent of the 1.3 billion people living in poverty worldwide are women (Peter, 1999). It is against this realisation, for example, that the Deputy UN Secretary-General has implored the international community to focus its development efforts on empowering women if international development goals are to be met by 2015:

> "…Empowering women is not just an end in itself; it is a prerequisite for reaching all of the Millennium Development Goals – our common vision to build a better world in the 21st century…" (Asha- Rose Migiro, 2008)

Furthermore, while it has been eloquently and logically argued that the health of nation is reflected by the health of its female population, many a developing country have not linked this realisation to policy implementation (Deogaonkar, 2004). Clearly, the role that women play in both informal and formal healthcare service delivery suggests a strong need for integration of gender needs and roles into transport research, policy and practice. Transport-related issues such as access to jobs, markets and social/educational facilities play a decisive, if unheralded role in perpetuating women's disadvantaged position in society. Whilst there has been visible effort to incorporate gender perspectives in the education and agricultural sectors, much fewer concerted attempts have been made in the transport sector. This is particularly unfortunate since transport plays such a vital role in the daily routines of most women (Buiten & Mashiri, 2006). Part of the reason, as the Moser Gender Analytical Framework has highlighted lies in planning in silos – a sin committed by most governments often to the detriment of women - as it does not take into account the interplay between women's triple roles – i.e. productive, reproductive and social.

The nexus between gender, transport and health has increasingly been gaining currency (Mashiri et al, 2005). Reproductive and sexual health issues that strongly affect, and are affected by women's socio-economic status, particularly in rural areas of developing countries, are increasingly being linked with issues of transport and mobility. Grieco (2005), for example, notes that "there is a relationship between mobility, power and well-being".

The relationship between maternal mortality rates and the speed of access to appropriate healthcare facilities is a strong one. Research on women's access to emergency care in rural Gambia, for example, concluded that women encounter a variety of problems when seeking healthcare, and highlighted the significant role of the lack of prompt responses to emergencies, distribution of health facilities, availability of transportation, road conditions and cost of transportation in causing high maternal mortality among pregnant women in rural areas (Cham et al, 2005).

While it is acknowledged that gender, transport and the formal healthcare system are interrelated, it is equally important to incorporate the informal healthcare issues in healthcare sector reforms. Just like its formal counterpart, informal healthcare systems in

rural areas require adequate and efficient transport services and infrastructure to deal with the demands the work generates (Mashiri et al, 2007). Furthermore, it should be noted that the expanding informal healthcare system in South Africa is significantly gendered (Mashiri et al, 2005a). The need to mainstream gender perspectives in all initiatives aimed at improving healthcare delivery particularly in rural areas, cannot be over-emphasized.

1.2 Organisation of the paper

This paper draws heavily from a case study conducted in 2007 by the CSIR in four villages in the Thaba Chweu municipality in Mpumalanga Province. The main purpose of the study was to unpack the relationship between rural healthcare delivery and mobility and accessibility within the ambit of the sustainable livelihoods approach. The case study highlights the importance of rural informal home-based care to the decentralised healthcare system in combating disease, isolation and to some extent, poverty and deprivation. It is also illustrates the importance of transportation infrastructure and services as well as communication in facilitating improved informal and formal healthcare service delivery. One strand of thought that filters through the paper is that the generation of gender sensitive intervention options that relieve the informal healthcare practitioners' "pain points" [which are largely access oriented] when providing services is crucial to sustaining and even improving healthcare service delivery.

A key dimension of the research findings is not only the important role played by the informal sector in overall rural healthcare delivery, but also the dominant role women play in the informal sector. This paper thus focuses on and seeks to unravel gender issues relating to the informal healthcare delivery system. In view of the foregoing, the paper has been divided into five main sections. *Section one* constitutes the introduction to the subject matter enumerating the importance of mainstreaming gender perspectives in development practice. *Section two* describes the case study research methodology, while *Section three* discusses the findings of the study. *Section four* presents some of the major recommendations of the study while the last section provides some concluding remarks.

2. METHODOLOGY

In terms of approach, the project was broadly divided into five phases, namely, project conceptualization (August 2006), stakeholder mapping and mobilization (October 2006), reconnaissance visits (November 2006), pilot investigations (January 2007) and main study (February-March 2007). A series of project workshops that took the form of brainstorms informed by extensive literature reviews were undertaken between August and October 2006 to refine the project focus, given the multiplicity of factors interacting to influence the provision of adequate healthcare, including the nexus between mobility and health. In order to determine and frame the research questions, the following hypotheses were generated:

- The largely point-based (spatially defined node from which services are dispensed – as opposed, for example, to mobile services) healthcare delivery system in rural South Africa cannot function effectively without the provision of a basic minimum level of transport infrastructure and service
- Rural home-based healthcare which is dominated by women strengthens the decentralized healthcare system by improving the accessibility and affordability of healthcare, particularly for chronically or terminally ill patients

A raft of qualitative and quantitative instruments was employed to gather data for the case study including focus group discussions and in-depth key informant interviews using a variety of checklists, visual condition assessment of transportation infrastructure and

services, self-administered and interviewer administered questionnaire surveys. as well as the accompanied walks where researchers accompanied home-based care practitioners on their usual round of visits to their “clients” – persons suffering mainly from HIV/AIDS related illnesses. Aspects of the trip that were investigated included; the length of the trip, the nature of the route (i.e. infrastructure audit of the route), the mode of travel (mostly non-motorized transport), how long it took (minutes), what was encountered along the way, as well as what needs to be done to ensure a better trip. At the end of each visitation, oral life histories with patients were conducted.

3. STUDY FINDINGS AND DISCUSSION

3.1 Moholoholo home-based care profile

Moholoholo community home-based care centre (MCC) based in Leroro village in the Thaba Chweu local authority is a community-based organisation which was established in 2000. It is currently registered as the Moholoholo Community Organisation (MCC). The following entities operate within the ambit of the MCC:

- Multipurpose community centre (MPCC)
- Community home-based care centre (HBC)
- Love Life campaign centre, and
- Planned Parenthood Association of South Africa (PPASA).

Table 1 below identifies a range of models within which home-based care organisations operate in South Africa (Russell & Schneider, 2000). MCC is a hybrid constituting models two through to five.

Table 1 Community-based care & support models in South Africa

Models		Type of Activity
1	Funding, technical assistance & support programmes	Umbrella structures channelling funds, providing technical assistance & monitoring & evaluation functions
2	Advocacy & community mobilisation	Community structures to protect the rights of individuals & facilitate access to health & welfare services & schooling
3	Drop-in centres /support groups	Physical facility that provides a space to run support groups & income-generating activities
4	Home visiting programmes	Home visiting, assistance with chores & psychological support
5	Comprehensive home-based care	Package involving palliative care & well-developed referral network to health facilities & welfare agencies

Table 2 below indicates that the 60 caregivers under the Moholoholo HBC stable service upwards of 1299 “clients” (incorporating 554 patients and 745 orphans and vulnerable children). Upwards of 60% of the patients are women. Just over half (50.5%) of the 554 patients (280) are living with HIV/AIDS and 236 have disabilities some of which are as a result of HIV/AIDS. Fifty-five percent of those with HIV/AIDS are women, which partly serves to confirm the view that women are more vulnerable to the pandemic than men. Of the 280 HIV/AIDS patients, only 13% are on anti-retrovirals (ARV), which implies more visitations to healthcare facilities as the disease matures. Each caregiver is responsible for upwards of ten patients. Given that the MCC is a charitable organisation dependent on funding from government and the private sector to discharge its responsibilities, it is clear

that the HBC sector in the area faces significant challenges in terms of resources and, by extension, accessibility to healthcare especially by women under its wing.

Table 2 Mohololoholo client base		
Village	Client/Patient	Orphans & Vulnerable Children
Leroro	87	222
Moremela	92	164
Matibidi A	99	192
Matibidi B	276	167
Total	554	745

The Mohololoholo HBC provides leadership to other entities operating under the auspices of the Mohololoholo Community Centre (MCC). MCC is partially funded by the Mpumalanga Department of Health and Social Services (MDHSS) especially with regard to providing caregivers' stipends and continuous capacity building through refresher courses and workshops. Currently, only 34 caregivers benefit from a government stipend of US$71 per month – a figure that is lower than the ruling rural minimum wage rate of US$96 (Department of Labour, 2006) for working 27 hours a week. Mohololoholo caregivers visit their clients thrice a week. Tuesdays and Thursdays are reserved for workshops and fetching clients' medication respectively.

3.2 Mohololoholo HBC services

The HBC consists of a board of seven directors, an executive committee of nine persons, twelve child carers and sixty caregivers. There are six males in the entire organisation, one in the executive committee and the other five providing care to clients, which serves to confirm the dominance of women in the care-giving fraternity. Intervention options relating to improving healthcare delivery through HBCs should thus necessarily take account of this dynamic in terms of targeting women.

Mohololoholo HBC offers comprehensive home-based care services including a package consisting of palliative care and a relatively well-developed referral network to healthcare facilities as well as welfare agencies. Some of its offerings include:

- Health education
    - Talks emphasizing and reinforcing the virtues of health-seeking behaviour
    - Condom distribution
    - Awareness campaigns
- Healthcare tasks e.g. direct observation, supervision of or administering prescribed medication such as TB and HIV/AIDS treatment (anti-retroviral regimes and opportunistic infections) and support (including counselling)
- Patient identification and referrals (this is a reciprocal activity between the clinic and the HBC in that either entity could potentially identify and refer a patient to be served by the other. Thus the clinic/hospital and the HBC have a symbiotic relationship that has been nurtured overtime, building on each other's strengths – the volunteers refers a case based on certain symptoms and the clinic/hospital staff make the diagnosis)
- Support activities include:
    - Bathing of terminally ill patients
    - Undertaking household duties for ill patients such as cooking, cleaning, etc.
    - Cooking meals for orphans and vulnerable children (OVCs)
    - Supervising homework for orphans
    - Working with social workers to identify those eligible for social grants

- Assisting with registering birth & dearth certificates

The duties and activities enumerated above are performed as part of a caregivers' daily visitation to households. On an average day, they spend close to six hours with their patients. In view of the array and intensity of selfless services provided by HBC practitioners, and talking to the patients themselves, it is not difficult to come to the inescapable conclusion that the HBC system has indeed enhanced the traditional point-based services delivery through service decentralization and diffusion. However, for HBC workers to achieve their goals in assisting the community, they collaborate with different spheres of government that are mainly responsible for the implementation of projects and programmes at a local level, as well as traditional and community leaders.

"…Our work involves caring & compassion with a view to assisting the most vulnerable to claim their rights in our community. Typically, these are individuals who have been stripped of the power & sometimes the will to claim their rightful place in society – they include children, the elderly, persons with disabilities, and those trapped by unemployment and poverty…"

Transcript of an in-depth interview with the MCC centre manager – Godfrey Malope: March 2007

3.3 Home-based care services defined

Home-based care by definition, is based in a patient's home, to which caregivers travel to provide a variety of health related assistance, running the gamut from medical, physical, educational, psychological, palliative to spiritual care and assistance for both patients and their families. Frequent visitations to clinics and hospitals, i.e. inpatient care, are not only significantly costly for patients, but public health services especially those in rural areas are often so overloaded and are forced to send patients home before full recovery. In particular, the additional burdens and pressures associated with HIV/AIDS, such as the exponential increase in chronic diseases or recurrent ill-health, and the additional burden on children and the elderly to care not only of themselves, but also of their households and their communities, have led to an inevitable rapid expansion and acceptance of this type of healthcare [Mashiri et al, 2004].

It is of interest to note that comparative research conducted in South Africa and Uganda showed that home-based care programs in South Africa are relatively inadequately developed compared to those in Uganda. For Akintola (2004), besides entrenching gender inequalities, many of the HBC programs in South Africa largely reflect a crisis management response and, therefore, are unsustainable. .

3.4 Caregivers' challenges

Moholoholo caregivers experience severe transportation challenges to access their clients given the spatial extent of the area they service and the mostly scattered homestead settlement pattern. The centre has thus allocated to each caregiver patients resident in their own settlement to reduce distances to be travelled as well as ensuring wider acceptability of the services they offer. On an average day, a caregiver walks about three hours and spends upwards of six hours with their patients to complete their daily round of client visitations. These activities add to their time poverty.

"…For a person living with HIV/AIDS, or any other chronic disease, there are many instances of transport or access requirements – for me to make my regular visit, I need transport; to get medicine from the hospital for them, I need transport; for them to go to the clinic accompanied by me or alone, they need transport; when they die, they need transport, sometimes to the mortuary, and back to the community graveyard or just directly

to the graveyard…all this costs money, which is difficult to come by…One just has to believe that God will provide…"

Transcript of an interview involving the life history of an HBC caregiver – March 2007

While communications infrastructure is relatively good at Moholoholo, cellular phone technology is seldom used by the caregivers due to cost considerations. Where cellular phones are used particularly with regard to emergencies, the caregiver often has to pay for the call. For this reason, the caregivers unanimously agreed that there was a need to devise a system of communication that would allow them to deal effectively with emergencies. And, given that the greater majority of their clients are terminally ill or just severely ill patients, emergencies are often frequent.

The clinic does not have its own vehicles, nor does it operate a mobile clinic. In cases of emergencies and patient referrals, there are significant challenges in terms of patient access to emergency medical transportation. In addition, even when transport services have been procured, the clinic cannot provide services after its designated working hours. Accessing the services of the hospital or private practice translates into additional costs the community can ill afford.

In return for the selfless volunteer work that they do, caregivers yearn for official recognition and acknowledgement commensurate with their weight of responsibilities. Home-based care practitioners eloquently argued in focus group discussions that part of the recognition could involve the provision of uniforms. In addition to such an act of recognition, caregivers were unanimous in their collective need for continuous capacity building.

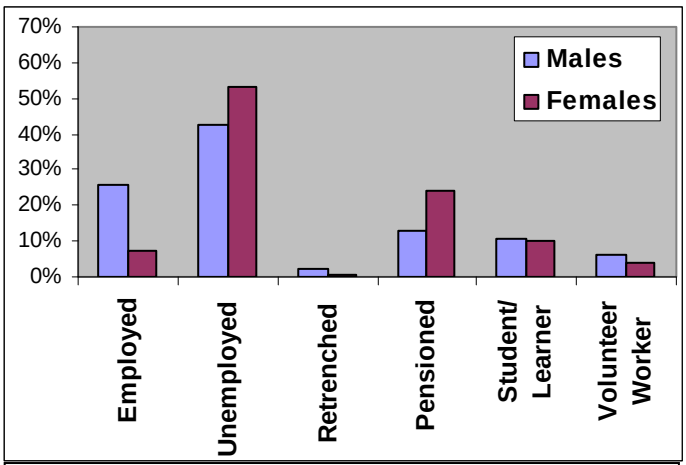

Figure 1 Participants' occupation by gender

Women provide more than 80% of paid as well as unpaid home care. As unpaid caregivers women are much more likely than men to provide personal care and offer emotional support. Men's contribution is more likely to be concentrated in care management, household maintenance, shopping and transportation. In other words, women are more likely to provide the care that is daily and inflexible while men provide care that can be more easily planned and organized around paid work (Women's Health Bureau, 2002)

In addition, as indicated in Figure 1 above, more women were unemployed which further underlines the view that because women are economically, socially and culturally dependent on men and thus have limited access to and control over resources, they are more likely to be excluded from making crucial decisions even about their health, endure restricted mobility, and are often under threat of violence from male relatives. In general, it was gathered that a woman is less likely to seek appropriate and early care for any ailment, whatever the socio-economic status of family might be because of their position in the family. This gender discrimination in healthcare access becomes more obvious where women are illiterate, unemployed, widowed or largely dependent on others (Deogaonkar, 2004). The importance of gender-sensitive intervention options that strengthen and

entrench women's decision-making positions in society cannot be over-emphasized.

3.5 Gendered mobility and health factors

A number of factors have been identified as constraining women's mobility. Figure 2, highlights respondents' preference of health facility differentiated by gender. Upwards of fifty percent of women prefer to use the local clinic mostly because they often have multiple chores in the household. They therefore do not have too much time to travel to a big hospital, where they could queue up for hours on end, and which is often impersonal – given the regular movement of personnel. Although not canvassed in this study, it was observed that women often use healthcare facilities much more than men do. In this regard, they often go for regular checkups striking a chord with the local healthcare personnel, which make it easier for them to explain their ailments. The local clinic is usually run by nurses who are often women – it is easier for a woman to disclose and discuss personal healthcare issues to another woman than it is to do so to a man. When a woman visits a hospital, she could be allocated to a male healthcare provider which could indeed impair communication.

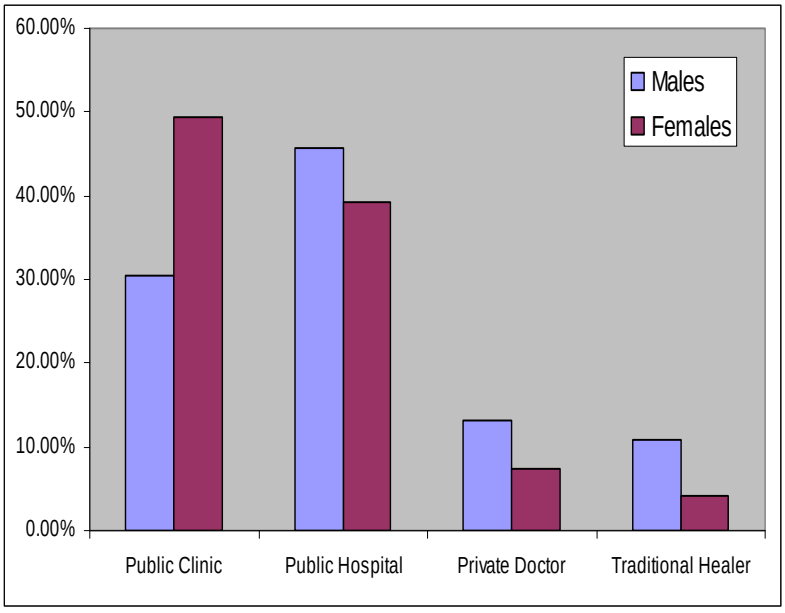

Figure 2 Preferred health facilities differentiated by gender

Major differences in the basic mobility needs of women and men are grounded in the gender-based division of labor within the family and community (Mashiri & Mahapa, 2002). Men's stereotypical role is one of a breadwinner, who leaves the house for work in the morning and comes back in the evening. Women, however, usually perform triple roles as income earners, home-makers, and community-managers. As a rule, they take shorter, more frequent and more dispersed trips during the day (Peter, 1999) – trips which they are unlikely to afford and which the public transport system is unlikely to accommodate even if women could afford them. When services are difficult to reach, travel costs may be more prohibitive for women than for men given that women among the poorer communities generally earn less than men and have less control over how household resources are spent (Carr, 2004:8). In addition, cultural norms and domestic chores and responsibilities may also truncate women's propensity to travel long distances, especially alone, to access healthcare. Clearly, the spatial location of healthcare services needs to respond to this reality.

Figure 3 presents access as an important factor in seeking care. Although villagers in the study area rated better service as a chief motivating factor for their stated preferences, significantly, upwards of fifty percent of respondents indicated access as an important issue influencing their decision matrix to choose a specific healthcare centre (in terms of time and financial resources). Special treatment refers to both better service and perhaps a specific infirmity that an institution regularly treats.

Although it does not stand out strongly as the other major decision pillars, cost, is also a significant factor in determining preference, especially for women whose meagre resources are hard-pressed to accommodate various household demands, let alone visitations to health facilities. It is intriguingly interesting that often, going to the hospital involves dressing up and looking more presentable than going to the local clinic which is costly in terms of time and other resources. This further serves to emphasize that the health experiences as well as the service needs of women are different from those of men which must necessarily be taken into account in the planning and provision of healthcare services. These differences primarily reflect gender roles relating to the social, cultural and economic circumstances of women' and men's lives. However, there has been little awareness in the healthcare sector on the ways in which these differences affect healthcare needs and the ways in which health services are used. It is, therefore important to understand how women and men's health experiences are different and yet intricately intertwined (Gordon et.al, n.d).

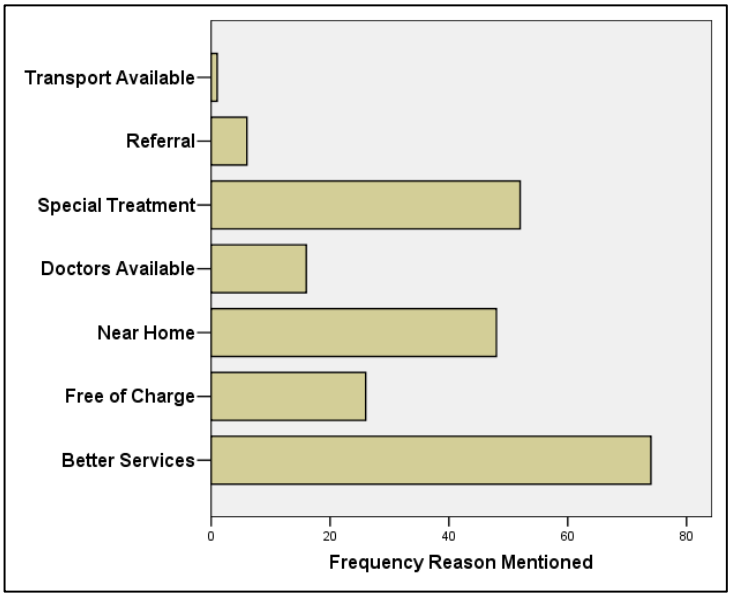

Figure 3 Rationale for preferring particular health facility

3.6 Transportation and access challenges

3.6.1 Public transport satisfaction levels

Although upwards of sixty-eight percent of all respondents were not satisfied with transport services to healthcare facilities especially to the hospital, women expressed more dissatisfaction chiefly because they undertake more visitations to health facilities, and thus tend to encounter this problem on a consistent basis than their male counterparts. Moreover, the gendered distribution of rural labour lends itself to high levels of involvement of women in household and community healthcare. Women are often the primary caregivers in their communities, within their own homes as well as through women's groups and home-based care organisations. Clearly, health and mobility issues have a far more profound impact on women than their male counterparts.

Most women respondents estimated the average waiting time for public transport to access healthcare facilities to an hour – half an hour more than men. This could stem from the fact that women have to undertake many chores before they go to hospital and therefore might miss the peak time (when there are more public transport vehicles on the road), which for a rural environment, is very narrow indeed. Due to gendered norms and power relations, especially in rural households, women's assigned roles and work burdens tend to confer a greater transport burden on women, whose socio-reproductive tasks often involve significant transport related work, coupled with socio-economic and socio-cultural factors that limit their access to transport resources (Venter et al, 2006). On the other hand, men who are less likely to be encumbered by such daily chores, often travel at the peak travel time when public transport vehicles frequencies are much higher. In addition, women are often accompanied by children and where a minibus taxi just needs one person, a man, who is usually alone, is able to board the minibus taxi, whereas the woman would be left behind.

Furthermore, it should be noted that the older the person, the harder it is to travel to healthcare facilities. Consultations held by HelpAge International with older women and men in over thirty countries, transport was repeatedly referred to as a principal concern (Madrid, 2002 sited by HelpAge International). Transport problems are often also related to older people's lack of finances to pay for transport to health centres, markets, pension collection points, meetings and social activities, leading to increased feelings of isolation. Problems related to transport are therefore likely to be more acute for older women, especially in rural areas of developing countries such as the case study area reviewed in this paper.

3.6.2 Waiting time at healthcare facilities

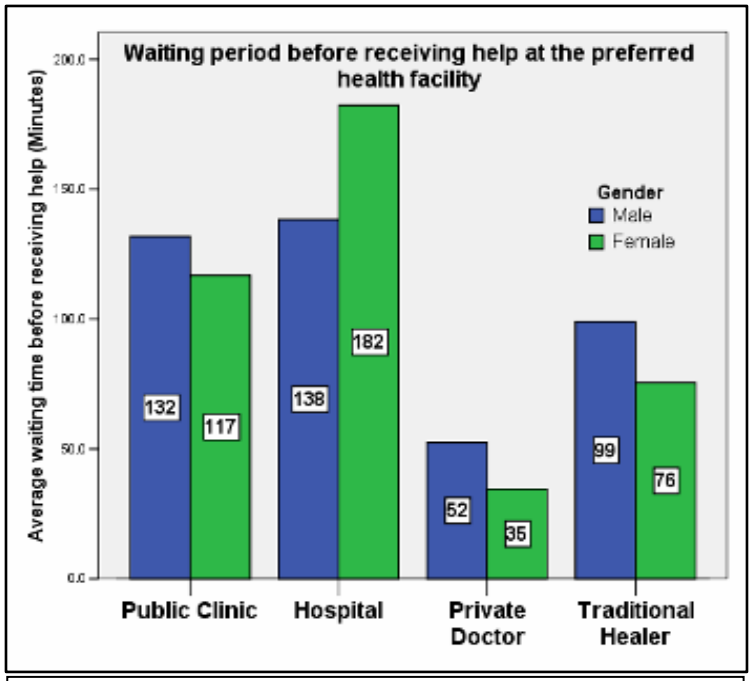

Figure 4 Average waiting time at health facilities

Most respondents agreed that the healthcare facilities they visit are always busy. Queuing is therefore considered normal. It may well be that the threshold for these facilities has been breached. Women often queue for longer periods than men, in part because they sometimes accompany other members of the household such as children (or in the case of caregivers – their patients). And because children have to undertake frequent visitations to healthcare facilities, their designated queues are usually much longer. Also because of their ability to communicate better than their male counterparts, women often describe their ailments in more graphic detail and thus health practitioners take more time going over the list of maladies. In contrast, in a public health institution with inadequate human resources, health practitioners are unlikely to voluntarily spend too much time trying to figure out other ailments that a male patient has not disclosed out of their own volition.

The average waiting time for males who prefer to use clinics and hospitals is nearly two and a half hours, while women queue for upwards of three hours at hospitals and two hours at clinics (refer to Figure 4 above). The average waiting period when visiting a private doctor is predictably less given that fewer patients who visit them largely because of the cost factor (a significant part of which is transport related). These are interminably long periods by any measure and tend, in the case of women, to add up to the time poverty that they experience. As indicated above, the picture becomes decidedly bleak when the time villagers spend walking to the main road and the time that they stand by the roadside waiting for public transport is added.

3.7 Gender issues in health sector reforms

While there are many examples of existing policies that focus on gender issues, there is a perception and concern that, although women's issues generally, and women's health in particular, are acknowledged, these factors remain essentially cast as a separate stream within projects or government departments. In addition, although there have been

frameworks on which to build a comprehensive, mainstreamed approach to gender, these do not adequately address informal healthcare delivery issues. An ability to visualise and measure the many and varied ways in which policies and programs can cause or lead to discriminatory effects is essential in effective scoping and assessing gender impacts around existing and new policy initiatives (Women's Health Bureau).

4. TOWARDS STRENGTHENING INFORMAL HEALTHCARE SERVICE

4.1 Overview

Reaching the poor requires new thinking about the most cost-effective service delivery for the different kinds of basic services – outreach, fixed facilities, and referral – all of which have a transport component.

4.2 Time poverty: Reducing time costs

Time spent waiting for transport or in-vehicle (including walking) due to poor roads, unreliable services or in the case of walking, affordability considerations, add up to significant time poverty for rural communities, especially women. In terms of affordability, alternative means of transport, especially non-motorised transport or intermediate means of transport has been herald as potential solution (Mashiri et al, 2005). Transport infrastructure improvements on roads, paths, footbridges and tracks, coupled with subsidized services linked healthcare access or low-cost but robust mobility aids such as bicycles or bicycle ambulances should be considered. Organisations such as the Bicycle Empowerment Network (BEN) are already attempting to address the issue of emergency transport in Namibia (Ibid). Incorporating these interventions would strengthen both informal and formal healthcare delivery. Planning, design and implementation of such interventions need to be gender-sensitive.

4.3 Empowering women

Empowering women to have control over financial resources is essential. As in the United Kingdom, it seems likely that the relatively positive impact that the South African pension program has on household health stems from the fact that it is paid to women (grandmothers) rather than to men. Other income-generating interventions should also be considered, particularly in the provision of transport infrastructure and services. Empowerment should also include women's ability to effectively participate in village administration so that they can make informed inputs, for example, about where a clinic or school should be located.

4.4 Strengthening home-based care service

HBC is increasingly being viewed as critical to the accessibility and affordability of health care, in particular, for chronically ill or terminally ill patients. The 2002 report on the future of Healthcare in Canada recommended that a "national platform for home-based care services" be enshrined in Health Act and that certain aspects of a national homecare program be implemented with immediate effect (Women's Health Bureau, 2002). Consensus is clearly building around the fact that a public program would be more efficient, effective, accessible and equitable than a piece-meal mix of private and public systems as currently obtains. Such a national home-based care program would need to adequately recognise, remunerate and value care work to enable men and women to make informed career choices. To ensure sustainability, it must be part of an integrated system that caters for a variety of needs and services and, that provides the conditions for continuous care by a stable workforce.

4.5 Information and communication technology

The poor quality and high cost of existing communications technologies limit the economic and educational opportunities available to isolated populations, and for many people, quality healthcare is physically and financially inaccessible. ICT provides scope for improved healthcare delivery, for example, telemedicine. Communication devices to enable caregivers to communicate with each, the centre and their patients should thus be investigated to facilitate better healthcare service.

5. CONCLUDING REMARKS

In the study area, rural healthcare delivery (particularly for the terminally ill), and by extension, the healthcare access burden appeared to have significantly shifted from the formal healthcare system (especially with regard to emergency cases) onto the shoulders of home-based care practitioners. In the same vein, the impact of HIV/AIDS on poverty and inequality has, to a considerable extent, been cushioned by informal safety nets and the oft practised tradition of reciprocal assistance within extended families. However, these safety nets are under severe strain from the high prevalence of HIV/AIDS, and are threatening to implode. In many cases, informal healthcare systems, including care voluntarily given in households and communities, are absorbing many of the pressures of healthcare problems in rural South Africa without the benefit of adequate resources and support. Most of these are run by women.

It is also clear from the study that although home-based care calls upon and utilizes the resources, skills, time, energy and funds of communities and governments, caregivers and their institutions still face significant challenges on a daily basis, not least of which is transportation. Women and men have differing patterns of mortality and morbidity, and have different roles in the provision of health and social care. These differences primarily reflect gender roles relating to the social, cultural and economic circumstances of women and men in society. It is essential that the healthcare service sector is sensitive to and takes into account these gender roles and their effect on rural healthcare and the ways in which changes in gender roles overtime impact on changing health needs. The study has illustrated that access considerations underpin both formal and informal healthcare delivery. However, interventions need to be gender-sensitive given the preponderance of women in rural healthcare.

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