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Gender and Health Sector Reform:
Analytical Perspectives on African Experience

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1. Introduction: gender equity, women's health needs and the assessment of health sector reform

Differences between women and men in roles, access to resources and decision-making powers are reflected in economic and social inequalities between the two sexes. In recognition of this, that different international fora have agreed on a number of actions necessary to advance gender equity. One such forum was the Fourth World Conference on Women held in Beijing in 1995. The Conference adopted the *Beijing Declaration and Platform for Action* which made specific recommendations on, among other topics, women and health. These included increasing women's access throughout the life cycle to appropriate, affordable, and quality health care; reducing maternal mortality by at least 75 percent of the 1990 levels by the year 2015; increasing resources for women's health; undertaking gender sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues; and encouraging both women and men to take responsibility for their sexual and reproductive behaviour (CEDPA 1996: pp 32). A specific recommendation was also made regarding the girl child – that of eliminating discrimination against girls in health and nutrition (ibid pp 36).

These recommendations clearly show how the issue of women's health is not only defined by their biological reproductive role, but also includes their general health as affected by social, cultural and economic factors in a broader societal context. Some interconnection between gender equality and women's health is picked up in the Millennium Development Goals that include gender equality and women's empowerment (specifically equal education for women) and better maternal health (specifically a sharp decline in maternal deaths) (www.undp.org/mdg 30.3.04). To move towards gender equity in health implies both the elimination of discrimination against women where male and female needs coincide, and attention to the differentiated needs of women including, but not limited to, reproductive health.

This paper draws upon these established themes in the literature on gender and health to explore perspectives on the gendered impacts of Health Sector Reforms (HSRs), with particular reference to African experience. We include implications for women's health that go beyond those related to reproductive health, and assess the impact of HSRs on women's health as affected by cultural, social, economic, and institutional constraints. In the health literature there has been extensive questioning of the extent to which the health sector reforms introduced in many low-income countries since the 1980s, with the stated objectives of improving, among other things, efficiency, equity and performance of health services have actually attained those objectives (Afford 2003, Mackintosh 2001, Koivusalo and Ollila 1997, G. Sen 2003, Turshen 1999, Mwabu 2001, Semboja and Thirkidsen 1995). This paper addresses one important aspect of equity, the impact of HSRs on women's access to and utilisation of health services, and some of its effects on outcomes in terms of women's health.

Our objectives however are primarily conceptual, rather than focusing on a compilation of existing evidence. We argue in Section 2 that the current literature on health sector reform in the African context (and indeed, internationally) is strikingly silent on the topic of gender. Gender is the 'silent term' in the model of HSR. Drawing on feminist writing internationally on gender and health, and on the (limited) literature on gender and HSR in low income contexts written from a feminist

perspective, we aim to break this silence. Thus Section 2 argues that the health sector reform model is implicitly gendered: the basic model of reform has gender built inaudibly into its assumptions.

The following sections draw together arguments and evidence concerning the gendered nature and impacts of health sector reform in Africa, drawing on the gender equity, women's health needs and gendered health systems approaches (all defined below). These approaches are not in contradiction, though we believe that an analysis based on the concept of gendered health systems will be particularly productive of additional future insights. Some aspects introduced by the gendered health systems approach are very little studied at present, and the paper identifies some areas for needed empirical research.

Our objectives in this paper are:

- To examine the conceptual issues arising in the study of health sector reform through a gender 'lens', considering the extent to which both process and outcomes of the reforms are gendered, and the extent to which that engendering process operates to the detriment of women, especially poor women;
- To set our arguments in the context of the existing literature on gender and health sector reform, and to illustrate them with a range of empirical evidence drawn largely but not exclusively from Africa; and
- To consider policy implications.

2. Analytical perspectives: health sector reform as gendered institutional change

Vignette 1

We visited several times in 1998/9 a small private dispensary in a town in the Tanzanian Southern Highlands. The dispensary was run on a day to day basis by a trained nurse, a woman. It was overseen by her husband, a medical doctor, who was not often there: he had a job in a mission-run hospital. The nurse saw patients, managed other staff, and did the books. Unusually, this private dispensary provided preventative care such as vaccinations and ante natal care (some without charge) as well as treatment for ailments. Most of the clients there on the days we visited were women, of varying ages, many bringing young children or other sick relatives, sometimes with their own complaints.

2.1 Gender: the silent term in health sector reform

Health systems are observed to be gendered institutions. That is, their organisation reflects and responds to gender inequalities in the wider society. For example, the hierarchy among health care staff tends to place doctors, policy makers and administrators – predominantly male – above nurses, paramedical staff and orderlies

who are more likely to be predominantly female. Furthermore, in Africa as in many parts of the world, day to day working relations between health care staff and patients tend to be rather predominantly relations among women, that is between nurses and lower level staff on the one hand, and on the other hand women accompanying sick children and the elderly, women caring for relatives who are inpatients, or coming for care themselves (Vignette 1). The established importance of mother and child health (MCH), and women's education in public health, to society's health outcomes, makes women's participation in health systems an important variable (WHO 2003a, LaFond 1995). All these aspects of gender and health systems are well known, and we set out some evidence below.

One would therefore expect, when we turn to the prescriptive and analytical literature on the health sector reform models that have been proposed and implemented across the sub-Saharan African sub-continent, that gender would be an important variable. The literature, one might expect, would address centrally how the reforms proposed would address women's needs.

Yet this is not so. The multilateral policy documents that proposed the reforms in the 1990s are largely silent on the topic. The influential *World Development Report 1993: Investing in Health* (World Bank 1993) mentions ante natal, delivery and post natal care and family planning as 'clinical interventions' that are 'highly cost effective' (ibid pp.9-10). It identifies the importance of schooling for girls and of 'educated mothers' (pp.14,42) and of women's access to income (p.41). It discusses the gendered pattern of disease burden (p.28) and the problem of insensitivity of health care to women's broader health needs (p 49). So far so good.

However, the moment we turn to proposed reforms, under the heading 'The roles of the government and the market in health' (p.52 ff), gender largely disappears from view. The cost effectiveness of MCH activities is affirmed (p.61) and the 'essential package' of recommended 'clinical interventions' includes ante natal, delivery and post natal care and family planning (p.112ff). But discussion of the core recommendation to introduce user fees does not consider gender differences in ability to pay, and the discussions of insurance, and of all the structural features of health sector reform such as decentralisation and competition similarly ignore gender (pp 118ff).

This pattern reappears in later documents such as the *World Development Report 1997: the State in a Changing World* (World Bank 1997): the discussion of 'new public management (NPM)' style reforms of the public sector (Chapter 5) contains no reference to the way these changes may differentially affect men and women, a silence characteristic of much of the NPM literature more generally. The most recent *World Development Report 2004: Making Services Work for Poor People* (World Bank 2004) discusses clients and providers, citizenship, and health services in a largely ungendered framework. Finally, this pattern also runs through the Millennium Goals agreements, which identify gender equity as an objective but are silent on the institutional changes that might be needed to eradicate gendered inequality from key public service institutions.

Despite these generalisations, there is some evidence that multilateral and international policies are shifting, most strikingly in the *World Health Report 2003:*

Shaping the Future (WHO 2003a). This report argues strongly for the importance of ‘principled, integrated care’ (p.105 ff), and it identifies problems of gender discrimination in the health professions as a serious problem for the delivery of services to poor and disadvantaged populations. The report also raises the issue of women’s participation in health care governance and management. One can characterise this approach as one which accepts that health care systems are themselves gendered institutions. We develop this concept of gendered systems further below.

2.2 What is ‘health sector reform’?

Health sector reform is not easy to analyse because it is used as an umbrella concept to refer to two distinct things. First, it refers to the processes of institutional change that have swept through African, as many other, health systems world wide since the 1980s. And second, it refers to an analytical and practical framework of proposals for institutional redesign of health care provision and public health, repeatedly proposed in ‘policy studies’, texts and consultancy reports. The two do not, of course, coincide. Health systems are messy, complex institutions, deeply influenced by cultural ideas about health and illness, by historical experience and by social structure. Health sector reform (HSR) models are themselves not without internal contradictions, and contain assumptions that may be problematic: we analyse several concerning gender below.

The outlines of the HSR model as promoted for middle and low income countries have been extensively rehearsed (World Bank 1993, WHO 2000a, Mills et al 2001, Gwatkin 2003). The emphasis within the ‘package’ has varied among countries, and the role of international organisations, such as the World Bank, in promoting and implementing the reforms has been important in practice (Lee et al 2002). In Africa health sector reform has particularly encompassed:

- liberalisation of private clinical provision and pharmaceutical sales, and promotion of a ‘mix’ of public, private and voluntary providers;
- retreat of government towards a mainly regulatory and priority setting role, with responsibility for direct provision of services in public health and for ensuring access to primary care for the poorest;
- increased use of contracting out of services funded by government to independent providers;
- decentralisation of health systems to local government control;
- user charges for government health services, for government-provided drugs and supplies, and for community-based health services;
- increase in autonomy of hospital management and finance; some hospital privatisation;
- a shift towards insurance rather than tax-based financing mechanisms including mutual insurance schemes.

We could summarise the model as a shift to greater ‘commodification’ of health care – that is, its provision as a set of discrete services for market payment or government ‘purchase’ on behalf of citizens – plus a pattern of reduction and decentralisation of government, and a greater use of systematic priority setting for government spending, based on cost-effectiveness of interventions.

In Africa, this HSR model has been promoted in a context of generalised and severe poverty, and has often begun to be implemented in the wake of an economic crisis. For example, in Tanzania re-introduction of for-profit private practice and introduction of user fees in government hospitals in the early 1990s took place at time when broader economic policies implemented since the mid 1980s were further marginalizing the poor. Cuts in government spending and removal of subsidies on basic goods were disproportionately affecting the poor who also now had to face increased out of pocket spending on health services.

Household budget survey data show that poverty was then and remains widespread. The 1991/92 Tanzania Household Budget Survey (HBS) showed that 38.6 percent of the households were living below the basic needs poverty line; the 2000/1 figure was 35.7% (URT 1992, NBS 2002). A World Bank country study (World Bank 2002) puts the number of Tanzanians living below a poverty line of US\$0.65 a day at between 15 and 18 million, out of a population (according to the 2002 census) of 43.4 million. Of these, about 12.5 million live in abject poverty. Thus user fees remain in effect within the context where a significant proportion of the population cannot afford basic needs including health care.

A similar economic background to the introduction of HSR, exacerbated by conflict, was observed in Uganda (Macrae et al 1996). In general, the extent of poverty in sub-Saharan Africa has profoundly influenced the consequences of the health sector reforms, since, for example, user fees were being promoted in a context of very low and often sporadic incomes which made access to cash in a crisis difficult to achieve. This is the background to the current poverty-focussed initiatives by African governments and donors to improve access to social services. In the health sector, there is increasing concern even from the World Bank that some aspects of HSRs are pushing poor households deeper into poverty, and commentary on the need for 'governments to invest in purchasing key services to protect poor households....' (World Bank, 2004: p. 133).

Some countries are already taking initiatives towards addressing inequalities in health that have been exacerbated by some elements of HSR such as user fees. For example, Uganda has recently abolished fees in the health sector, and Ghana is seeking to move this year to a national health insurance framework. In Tanzania, a current study commissioned by the Research and Analysis Working Group (RAWG) of the Poverty Monitoring System aims, among other things, to identify options for revising the current user fee system in the health sector to achieve greater equity. The study is intended to contribute to the review of the Poverty Reduction Strategy (PRS) (URT 2000).

2.3 Identifying gender perspectives on HSR

To the extent that the differential impact of these health sector reform models on men and women have been studied, what have been the analytical frameworks employed? The literature relevant to reform in low and middle income countries currently offers two broad perspectives for assessing the differential impact of HSRs on women (Standing 1997, 2002a). One is a 'gender equity' perspective. This picks up from the broader health literature the concept of equity of provision of services, in the sense of equal response to equal need and greater resources for those in greater need. It then

applies this concept to equity between women and men in access to health services, asking whether health care systems respond equally to men and women in equal need. This in turn allows one to ask, do women experience equity of treatment? Does HSR improve equity in this sense? And does the HSR model set out ways to do so? We consider some evidence on these issues below.

The second perspective available is not wholly distinct, but has been called the women's health needs' perspective. It focuses particularly on the specific health needs of women, notably (but not only) the field of reproductive health. This too allows us to ask questions of health systems and HSR. Do health systems respond to these needs? Does HSR in practice improve the situation? Does the model of HSR seek to do so? Again, we consider some evidence below.

These perspectives, illuminating as they are, do not provide a rich enough framework for evaluating HSR through a gender 'lens'. As Standing (2002a, 2002b) points out, many other aspects of health care, and hence of health sector reforms, are marked by sharp gender differences. These include the role of women as workers in health care, predominating at lower levels and frequently facing 'retrenchment' when services are cut, and the tendency of reformers and donors to separate off sexual and reproductive health as 'vertical programmes' to be delivered apart from other health care.

Following this lead, can we give more depth to the concept of HSR as a gendered institutional process? What this might entail can be identified by comparing the existing literature relevant to HSR and gender in Africa with two other literatures. These are, first, the broader literature on gender and *health*, and second with the gender analysis of high income countries' health and welfare systems.

Some of the gender and health literature (for example, G. Sen et al 2002, Okojie 1994, Vlassof 1994) examines women's health using the concept of a 'gender lens' (G. Sen et al 2002 p.6). Gender is here understood as referring to structural inequalities between men and women, and associated sets of behaviours, expectations and roles for men and women. In this framework, concepts of health and illness, and the ideas that shape health seeking behaviour, are demonstrated to be themselves gendered. Gender, in other words, :

'permeates social institutions, as it refers not only to relations between the sexes at the individual level, but also to a complex array of structures, practices and behaviours that define the organisational systems that constitute human societies'. (ibid p.6)

This is also our usage in this paper: for us too, a 'gender lens' means an examination of – in this case – health sector reform, based on the concept of gender as an 'organising principle of social life' (ibid).

This gender and health literature raises, but does not explore in depth, the way in which the institutions of health systems are permeated by gender. However, some literature on rich country health and welfare systems has addressed this issue (for example J. Lewis 2002, 1998; Williams 1989; G. Lewis 1998; Lister 2000, Zimmerman and Hill 2000). In drawing on that literature here, our interest here is

not so much in the precise analysis as in the *type* of conceptual questions addressed. These include questions like the following.

- What are the assumptions about *household and family structure* that underlie health sector reform and are they justified? In rich countries, there is debate about the extent to which health financing strategies (such as the structure of social insurance) respond to changing social understandings and experience of women's financial dependence or autonomy within the household and role in health care decisions.
- What are the assumptions about *women's labour market participation* – including participation in the health sector labour force. In rich countries there is a debate about the extent to which wider work opportunities for women and changing expectations about treatment at work influence, for example, the nursing labour market.
- What are the assumptions about *women's capacity to undertake unpaid care*? In rich countries, there is a debate about the extent to which health care reform makes unjustified assumptions about women's availability e.g. to care for sick children and the elderly.
- How do *changes in health care funding and expenditure* affect differentially women and men in different social groups? A shift in the pattern of public expenditure on health care, in the structure of the tax system, and in the balance between public and private health finance can all have gender-differentiated effects, and 'women's budget groups' have raised these issues in both high and low income countries.
- To what extent do health and social services *influence women's circumstances* as well as responding to them? In the literature on high income countries, there are discussions of the ways in which the services construct the kinds of citizens women are, the rights they have, and in differentiated ways according to differences of income, social class, ethnicity or location.
- What are the assumptions about *health sector governance* in reformed frameworks: who will participate and how? The extent to which users from a variety of social categories can exert leverage over resources through governance structures is widely debated in rich countries.

Most generally, some of this high-income country-focused literature treats health system as themselves 'gendered' in the sense outlined above. That is, a health system as it has built up historically is expressive of the gender hierarchies (as well as the other forms of hierarchy) of the wider society; and the health system thus feeds back into social patterns of disadvantage. Similarly the standards and principles of evaluation of health systems and the reform models themselves reflect patterns of established disadvantage including gender hierarchies (Twigg 2000, Mackintosh 1998). Conversely, because health systems are of immense political and social importance, and because health care provision has been frequently associated with response to political and economic crisis, health systems *can be*, and in rich countries as in poor have been at times, sites of challenge to gender disadvantage.

So can we contribute to the construction of a relevant set of analytical questions, at this level of abstraction, for the African evidence? We seek to do so here.

3. Health Finance and Gender Disadvantage

Questions:

How do changes in health care funding and expenditure affect differentially women and men in different social groups?

What are the underlying assumptions about women's access to cash and are they correct?

We begin where much of the critical literature on HSR in Africa has begun, with the inequitable implications of the shift to user fees (or 'cash and carry' payment) and more broadly to fee-for-service systems in government as well as private health facilities. HSR in Africa has formed a key element of 'informal commercialisation' of health systems: that is, the rising importance of small scale unregulated provision and informal payment systems coexisting with low income formal user fee systems (Tibandebage 1999, Tibandebage et al 2001, Mackintosh 2003). A widespread policy response has been to try to develop prepayment insurance systems (Tibandebage 2004).

So far evidence on the gendered impact of these payment systems remains thin as studies to assess such impact remain few. This is the case even for financing reforms such as mutual insurance whose objective was, among others, to improve access to sustainable health care. There is now an increasing emphasis placed by donors on the 'pro-poor' use of public finance, notably in health and education, through the preparation of Poverty Reduction Strategy Papers (PRSPs), but public expenditure tracking exercises and monitoring of expenditure incidence rarely disaggregate the poor by gender. In this section we address the gendered impact of the financial aspects of HSRs on access to affordable, good quality health care, and question the underlying assumptions of these financing models.

3.1 User Fees

Introduced since the 1980s at hospital level in a number of low income countries, user fees have since increasingly been extended to some lower level government health facilities providing basic curative services. While a number of studies have assessed the impact of user fees on the poor in various countries, with results showing that user fees accompanied by an ineffective exemption system have indeed increased exclusion of those unable to pay (Gertler and Van der Gaag 1990; Karanja et al. 1995; Booth et al. 1995; Gilson 1997; Newbrander and Sacca, 1996), studies aimed at specifically assessing the gendered impact of user fees remain few. Nonetheless limited evidence exists, indicating that women have been disproportionately affected adversely by the reforms.

Studies undertaken particularly in some Sub Saharan Africa (SSA) countries mainly in the area of reproductive health indeed show that introduction of user fees at the point of use in health facilities has been associated with a decline in admissions of pregnant women and increased morbidity rates among delivering mothers and their

babies¹ (Simms et al. 2001 cited in Standing 2002). For example, evidence from Nigeria (Ekwempu et al. 1990), Zimbabwe (Kutzin 1993), Tanzania (Walraven 1996)) show that introduction of user fees in government hospitals was associated with decrease in the number of hospital admissions of pregnant women, increase in maternal deaths and a decline in the use of Maternal and Child Health (MCH) services. A study on Nigerian Factory workers during the adjustment period (Abdullah, 2000) shows a reduction in seeking health care by the respondents when ill. Care was sought only in cases of critical illness, which they described as when unable to get out of bed (pp. 132). A summary of data on the impact of user fees in other developing countries also show similar outcomes. For example, in India although cases of untreated illnesses were common among the poor in general, the situation was worse among women and girls (G. Sen, 2003).

While it has been shown that the demand for health care among the poor is highly price elastic (Gertler and Van der Gaag 1990), evidence on such a relationship in the case of women remains scanty. Standing (2002c) points out however, that “anecdotally expenditure on health care for women and girls in some contexts is even more sensitive to price changes” (pp. 17). Results (2004) cites data from Kenya showing that following the introduction of user fees at a special treatment clinic for STDs in Nairobi, the drop in attendance over a nice month period was significantly higher among women compared to men (65 percent and 40 percent for women and men respectively). Out of pocket spending on health services is indeed likely disproportionately to affect women negatively. This is because not only do women often have to take care of their own and their children’s health, but they are, at the same time disproportionately disadvantaged in access to income.

Exemption of those unable to pay user fees is usually provided for in user fees guidelines. However, evidence suggests that this has largely been ineffective. For example, in Tanzania the exemption policy has not worked for the poor, who often are not even aware that such provision is in place. Often the exemption policy has been found to benefit those not eligible such as hospital staff and relatives of health facility workers (Tibandebage and Mackintosh, 2002). The *World Development Report 2000* (WDR) on poverty notes that in most African countries exemptions tend to benefit wealthier groups such as civil servants (World Bank 2000). In a more specific example, the WDR points out that in Volta region, Ghana only about 1 percent of the patients got exemptions, with 77 percent of the exemptions going to health service staff. It has also been shown that sometimes those eligible for exemption are not even aware of their eligibility. For example, in a study by Newbrander and Sacca (op cit.), 62 percent of the respondents of whom 81 percent were classified as poor thought they had to pay for health care in government hospitals.

3.2 Health Insurance Schemes

Health insurance is one of the health care financing reforms taking place in low-income countries. We discuss the gendered impact of two types of health insurance – social health insurance for those in formal employment and Mutual Health Insurance (MHI) schemes.

¹ Standing (2002c) also notes other factors that influence low utilization and hidden costs of free health care. Particularly applying to women cited factors include “the opportunity costs of time spent in travelling to facilities, and waiting to see staff.

Social Health Insurance

This type of insurance provides coverage only for workers in formal employment. Gilson and Mills (1995) point out that eight countries in SSA including Kenya were said to have some form of social health insurance. The authors also mention five countries – Ethiopia, Ghana, Nigeria, Mozambique and Zimbabwe as having been reported at a meeting of African officials to be considering implementation of social insurance. Tanzania introduced a social insurance scheme – the National Health Insurance Fund (NHIF) in 2001.

One area of concern with regard to social health insurance is that of equity. Because social health insurance in low-income countries targets people in formal employment, it only serves a very small proportion of the population and these are the ones who are likely to be more economically advantaged. In Tanzania, the NHIF currently covers less than 300,000 civil servants, out of a total population of about 32 million people. Gilson and Mills (op cit.) note that social insurance schemes cover the formally-employed, who are usually less than 10 percent of the population.

Looking at social health insurance from a gender perspective, two issues emerge, which show that social health insurance benefits more men than women. First, very few women are in formal sector employment compared to men. This is likely to remain the case even if we consider that social insurance schemes generally cover dependants. Second, the majority of women in formal sector employment are concentrated in low status poorly paid occupations, or occupying lower level positions.

Unfortunately, data on wage employment in Africa rarely distinguish formal and informal wage employment by gender. Table 1 shows the proportion of women in non-agricultural wage employment in selected SSA countries; only in Kenya is this percentage over 50%; in the others it is less than a third. Table 2 shows the male/female breakdown of waged and salaried work for selected countries. It shows that while women are highly active economically, they are much less likely than men to receive a wage or salary for their work.

Table 1 Female share (%) of non-agriculture wage employment in selected SSA countries, 2001

Country	Percent share
Kenya	58
Malawi	12
Swaziland	30
Zimbabwe	20

Source: UNDP (2003)

Table 2 Percentage of the labour force female, and percentage of the male and female labour force receiving wages or salaries, various years

Country	Year	% labour force female	% male labour force waged	% female labour force waged
Ghana	1990	51	33	9
Uganda	1995	48	21	7
Kenya	1995	46	32	12

Source: World Bank GenderStats <http://devdata.worldbank.org/genderstats> 27.4.04

Mutual Health Insurance (MHI) Schemes

Another health care financing alternative, which is perceived to promote inclusion of the poor and other vulnerable groups is that of Mutual Health Insurance (MHI) schemes. One form of MHI schemes introduced in several SSA countries is community-based voluntary pre-payment schemes. These schemes have been designed with features to promote inclusion such as paying premium in instalments, having provision for exemption of those unable to pay premiums, and paying during harvest time for those with unsteady seasonal income.

Assessment of the implementation of these schemes however reveals a number of shortfalls in attaining the objectives underlying design of the schemes. First, community-based schemes continue to face a problem of very low participation rates. In Tanzania for example, a study reviewing the performance of one of the Community Health Fund (CHF) schemes (Tibandebage, 2004) show the scheme, which became operational in 1998 having by November 2003, a participation rate of only about three percent. Other assessment reports show similar schemes in other districts also having very low participation rates of less than 10 percent.

Evidence from other developing countries show a similar picture of very low enrolment rates (Jutting and Tine, 2000). Inability to pay is one of the reasons given by non-members, although other reasons such as lack of transparency and a decision-making process that does not effectively involve members have been cited as well. A research paper assessing the gendered impacts of MHIs in Tanzania (Tibandebage, op cit.) shows evidence of inability to pay by some rural households as revealed in previous CHF assessment reports and also by focus group discussants for the study. Evidence from other developing countries also identify inability to pay as one factor contributing to low participation rates (Jutting and Tine, op cit.; Wiesmann and Jutting, 2000).

From the gender equity point of view, very low membership numbers in community-based schemes is likely to disproportionately affect women. This is both in terms of being less able than men to afford out of pocket payments at the time of illness, and also because women are likely to have more health needs. Among scheme members, implementation problems are likely to disproportionately affect women members. For example, a recent assessment of one CHF in Tanzania show that members were not aware of some of the benefits they were entitled to such as referral to a hospital. This could have disastrous consequences for example in cases of women with complicated pregnancies in need of hospital level care but with no out of pocket cash.

MHI schemes such as CHF have provision for exemption of poor households from paying premiums. However, as in the case of user fees, implementation of this provision has been weak. This again means that women who generally have lower incomes than men, are disproportionately affected.

3.3 Who pays? Assumptions about women's access to income

What are the assumptions embodied in these payment mechanisms about control of income individually and within the household? These assumptions are never, as far as we can find, made explicit in reform documents. Since women are disproportionately greater users of services than men – in good part because women generally accompany young children and other ill family members to facilities – the assumptions seems to be either that they have access to household income, and funds borrowed from others, to support these visits, or that they can pay from their own incomes.

Societies vary widely in the extent to which funds are 'pooled' in a household under the control of one person, or conversely funds are retained by those who earn them and are spent according to understood norms of responsibility. Societies also vary greatly in the extent to which reciprocal saving schemes operate among neighbours and families to support medical and other expenses such as funerals and weddings. Generalisations are difficult to make, but we could risk two: that in many African societies, women need to raise money to contribute to the support of their children, and that African societies are rich in mutual savings schemes also frequently run by women.

The literature documents many forms of mutual resource support for health care costs in poor communities: sharing of information and medicines, networks of personalised contacts with health workers; sharing domestic work to allow others to work of cash to pay fees; and mutual loans and gifts of cash for fees (Mackintosh and Gilson 2002, Booth et al 1995, MacCormack and Lwihula 1983, Gilson et al 1994, Moser 1998, Sauerborn et al 1996).

However women's earning power, as noted above, is generally less than that of men. It seems very likely therefore that HSR, by imposing official user fee systems on a pay as you go basis, have sharply increased women's need for cash to cope with their responsibilities for accessing treatment for family members who are ill. No doubt men also contribute; we know very little about who pays. Nevertheless, the additional strain of the 'cash and carry' payment system on low income women is likely to be large. There is furthermore evidence that falling incomes and economic crisis undermine, as one might expect, women's participation in networks of mutual financial support (Moser 1998).

In mutual health insurance, there is some evidence that building on existing co-operative savings and loan schemes works better than stand alone schemes since they are rooted in existing patterns of economic solidarity (Atim 1999, Mackintosh and Gilson 2002). The UMASIDA insurance system in Tanzania (Tibandage 2004, Kiwara 2000) builds on existing co-operative groups in the informal sector, including some women's groups; similarly but on a larger scale, the health insurance scheme built in India by the SEWA organisation has become well established (Ranson 2002).

However World Bank and donor support has generally gone to stand-alone schemes (Atim 1999).

One can summarise, therefore, that an underlying – largely unrecognised – assumption behind the financing reforms in HSR was that women's incomes and mutual support networks were robust enough to withstand the payments demanded. The sharp decline in usage, and low levels of commitment to community insurance schemes documented above, show how unrealistic that assumption was in contexts of generalised poverty.

3.4 The gendered impact of public expenditure on health, and the need for an integrated assessment of health finance

Health sector reforms which have promoted inequalitarian and implicitly discriminatory private funding mechanisms have sometimes been justified on the grounds that the development of private provision results in the shift of the better off to the private sector and a more progressive expenditure of remaining public finance for health care. There are serious doubts about this proposition among both policy makers and academics: privatisation sets up its own political pressures for subsidy and can 'leech' public sector assets through sale, theft and 'informal' use (K.Sen 2003), while those African governments seeking to improve health spending allocation face huge competing pressures, for example to sustain basic hospital services in the face of falling expenditure. Even where there has been a real increase in support for primary care, user fees can block use of the improved services by the poor, who also continue to struggle to pay for non-government provision (Kida and Mackintosh 2004).

Furthermore, as noted above, few assessments of who benefits from public expenditure, disaggregate the poor by gender; for example recent detailed assessments of poverty and budget processes do not mention gender (Naschold and Fozzard 2002, Booth and Lucas 2002, van der Westhuizen 2004). The majority of work on gender disaggregation of public expenditure and taxation has instead been done in the context of 'women's budgets' or 'gender sensitive' budgets. These initiatives have been widely promoted by NGOs and quite widely undertaken within governments across Africa as well as in high income countries (Budlender 2000). South Africa in particular has been the context for a series of women's budget exercises, in and Tanzania, Uganda, Botswana, Malawi and Mozambique there have been attempts to explore the gender aspects of the national budgets (ibid, Tanzania Gender Networking Programme 1999). The techniques of gender budgeting have been disseminated by, among others, the Commonwealth Secretariat (Mukhopadhyay et al 2002) and UNIFEM.

These women's budget exercises have explored the accessibility of the budget making process to women, the extent of programmes specifically addressing women's needs (such as reproductive health) and the gendered impact of the main sectoral programmes such as health (Budlender 1997). This has not been easy, especially at the local level; interviewees for a South African Women's Budget study indicated the contributions to health services from local government own revenue appeared to be a 'state secret' (Klugman and McIntyre 2000). Participants in South Africa, Tanzania and Uganda have all emphasised that much initial work has gone into trying to get

access to information in a form relevant to assessing its impact on women, and that women politicians have been important in pressing for and publicising information (Fleshman 2002). The Tanzanian NGOs working on gender and budgets had trouble at first in getting access to the national public expenditure review (PER) process, but the Tanzania Gender Networking Programme (TGNP) later became an invited member of PER meetings. TGNP were also commissioned to contribute to the PRSP process, and have lobbied successfully for gender-relevant indicators in monitoring health spending (Bridge 2004). In Uganda, the importance of increased spending on primary health care has been one focus of attention (Fleshman 2002).

These gender analyses of government health spending are a key contribution to our understanding of the impact of health finance changes on women, and several groups have turned their attention to the gender aspects of tax structure as well as spending. To assess the gendered impact of HSR implies integrating the assessment of fees and public finance in terms of their differential impact on women. As yet, such an analysis has not, to our knowledge been done. It seems likely that it would discover, in some African countries, a pattern of contradictory shifts as a result of HSR: a regressive impact of fees and 'cash and carry' on for poor women, countered to some extent by the progressive potential of increased spending on lower level health care, but in a context where the user fees form a barrier to access to those lower level public services by the poorest, including many women.

4. Liberalisation and privatisation in health care: women as users and workers

Questions:

How has HSR affected the conditions of women as health care workers?

How have those changes influenced women's experience as health care users and citizens?

What are the assumptions underlying HSR about gender and quality of care and are they correct?

A key aspect of health sector reforms in Sub-Saharan Africa has been market liberalisation, including the liberalisation of private practice. In Tanzania for example, private clinical practice was permitted in 1991, after being banned, outside mission facilities, since 1977. Across the sub-continent, small scale private practice, formal and informal, expanded in the wake of the economic crisis of the 1980s, as health workers sought to supplement plummeting public sector incomes with fees from private patients. Dual practice, in both public and private sectors, became common for doctors and nurses, as did the practice of informal charging in public facilities. Private provision, largely unregulated, much of it of dubious quality, became particularly widespread in urban areas across Africa (Tibandebage et al 2001, Koivusalo and Mackintosh 2004, Bennett et al 1997, Mills et al 2001, Alubo 2001).

These changes were the context of HSR, and were reinforced by HSR policies. They influenced the labour market and working experience of doctors and nurses in ways that appear to have been gender differentiated, though data are poor. At the same time another pattern of liberalisation was under way: in the international labour market for doctors and nurses. Particularly from the mid-1990s there were increasing opportunities for both doctors and nurses to work overseas. The crises and patterns

of liberalisation in turn affected the experience of patients in gender-differentiated ways.

4.1 Gendered private provision for the poor and its consequences

The conceptual framework within which privatisation of health service provision is discussed tends to be an individualist one: health services are (re)defined as commodities for which individuals pay. Gender appears to be an *entirely* silent term in the privatisation literature. However, as the first vignette recorded, many of the relationships of private provision and use occur between women, and the terms of payment and the nature of services offered all have gendered effects.

As the ILO notes, ‘in most countries the workforce in the health sector is predominantly female’, yet ‘they fall at the bottom of the hierarchy in terms of authority, remuneration and qualification’ (www.ilo.org/dialogue 27.4.04). Surveys and case studies repeatedly confirm this, though data are hard to come by (WHO 2003b, Ngufor 1999 on Cameroons, Corkery 2000 on Uganda). The observation is likely to hold for both private and public sectors across Africa, despite a tradition in some countries, including Mozambique, of men going into nursing. The implication is that the working pressures generated in the health sector reform period including downward pressure on wages and professionalism, are likely to have fallen particularly strongly on women health workers.

We know however rather little about women’s work conditions in the private sector. While at the upper end, the private clinics frequently appear to provide nurses with better working conditions than the public sector², this is not so at the lower end. Indeed, wages and working conditions in a number of countries tend to be worse now in the small scale private sector than in the urban public sector, because of overcrowding and competition in the small scale private market. Private employers try to keep down costs by reducing wages, and by offering no training; those who employ trained staff on decent wages find themselves undercut by those who do not (Tibandebage and Mackintosh 2002). As a result, very low income women users find themselves paying money they cannot afford, in a crisis, to very low paid women employees: a vicious circle of gender disadvantage.

That vicious circle is reinforced by low quality in much of the small scale unregulated private sector. As predominant users of services, on behalf of children or themselves, women are vulnerable to cheating. And much of the low income small scale private sector provides poor quality: low levels of training and the use of untrained staff, the use of expired drugs, very poor diagnosis, over-prescribing and outright cheating, failure to identify and refer serious cases, low levels of participation in immunisation and public health education. In many African countries, the poor depend quite heavily on private providers, and those with the lowest income are more vulnerable to abuse.

Conversely, however, there are private sector exceptions to these generalisations: some small private dispensaries visited in Tanzania in 1998 were doing preventative

² Anecdotally, this seems to be the case in Accra, Ghana, where highly skilled nurses have moved from the government hospitals to private specialist clinics.

care, and some private providers catering partly or wholly for the better off displayed higher levels of probity. The former case of better provision to low income populations included the private dispensary referred to in Vignette 1. There, the doctor explained that they saw vaccinations and ante-natal care as a way of drawing people in, who might then come back when they or their children were sick. This use of preventative health care as a way of marketing the dispensary services was thus directed to women. The key to financial survival, in a market where many private dispensaries were going bankrupt, was, they thought, to build up a good relationship between the largely female staff and the largely female patients. Patients interviewed, all but one female, indicated that they valued the pleasant manner of the staff, and the short waiting times and lack of hassle, but that finding the money for the treatment was a serious problem.

4.3 Gendered hierarchy in the public sector and its consequences post-reform

Investigation of the implications for women of gendered hierarchy in government health services has particularly focused on the situation of nurses. There is evidence that the liberalisation of private practice and the rise of informal and formal charging, alongside severe deterioration in the funding of the government sector, has created severe strains and demoralisation for many nurses working in the public sector.

The research literature documents public dissatisfaction with rude and abusive behaviour by some government health care staff towards patients; there is a particular literature on aggressive treatment by some nurses and midwives of women in maternity wards (Bassett et al 1997, Gilson et al 1994, Jewkes et al 1998, Tibandebage and Mackintosh 2002). Jewkes et al (1998) found in South Africa that low-income patients, and those regarded as reprehensible such as teenagers, were most likely to face abuse.

There are, however two sides of this story of mistreatment of women by women, and during some research the authors did in Tanzania in 1998, a matron in a maternity hospital put the nurses' side of the story (Vignette 2):

Vignette 2

This kind of thing [bad behaviour] happens, and it is because of poor morale, low commitment, severe overwork and low salaries. Imagine, you are a nurse on duty for 12 hours. You start at 6 a.m., you may get away at 7.30 p.m. You may have a ward of 40-60 seriously ill patients. In gynaecology, you are likely to have several emergencies, some operations, post-operative patients, very sick patients. You are two trained people at best. How will you divide yourself? You are constantly over-working and under pressure. You are worried about family problems and commitments. For twelve hours you do not know what is happening to your children. And you may not have as much as a cup of tea. Then there is the problem of the commitments of other staff. You are a nurse by profession. The doctor, who is supposed to be responsible, works his official hours and he goes away, he waits to be called. You are there, someone is bleeding and you cannot help them. She needs to be operated, no one is there, there are no facilities. People are suffering, and the other staff are not on duty. The means to save this lady are not available. If someone is supposed to be on duty and is not there, what can you do as a nurse? There are no infusions, no emergency drugs, you cannot save people. Relatives rush to send the sick person to hospital, then we are not in a position to help the patient.

These arguments were heartfelt. It seems likely that public sector decline and health sector liberalisation have widened the gap in wages and working conditions between doctors and nurses. Not all doctors can benefit from additional private practice, but many do; nurses have found that benefit harder to achieve. The 'going rate' for informal payments to doctors we found to be substantially higher than those for nurses.

The problem has been compounded, as Vignette 2 suggests, by the rigid existing work hierarchies. Nurses have far more contact with patients than doctors, and when the service falls apart they take most of the strain. The matron quoted above went on to describe a situation of acute shortage of trained nurses; very low pay associated with the loss of allowances (such as for transport and uniforms, which they now had to pay for) as a result of reform; lack of access to training opportunities since specialist nurse training courses now had to be paid for by the nurses themselves 'and if people have a family they simply don't see this as a possibility'.

The result, as this matron told us in 1998 was that nurses had started to go abroad, initially from Tanzania to Zimbabwe. In the five years since then, this flow has accelerated, as high-income countries have started more actively to recruit African nurses (Mensah 2004). Doctors migrate too, and, in Ghana for example, the bulk of incentives aimed at encouraging health care staff to remain have been focused on doctors. As a result, the 'pull' of more active recruiting of nurses has converged with the 'push' of increasing resentment among nurses about the gap between their work conditions and those of doctors. Given that, as Mensah puts it, nurses are the 'backbone' of African health services, the rising out-migration is having extremely serious effects on services, and very specifically on primary provision on which low income women predominantly rely.

4.4 Gendered assumptions and opportunities for change

It therefore seems clear that the effects of HSR have been differentially problematic for women staff as compared to men within health systems in Africa. Yet the human resource aspects of HSR have rather rarely been examined, in the last twenty years, as a gendered process. This widespread silence is not unique, furthermore, to HSR in Africa.

A large literature on the human relations aspects of health care reform in the UK, for example, avoids the framing of the reforms as gendered institutional change; thus a recent analysis of the 'lessons' of the human resources aspect of UK HSR for other countries, by a researcher who has written extensively on nursing, mentions neither 'gender' nor 'women' (Buchan 2000). Investigation of the UK reforms in the 1990s suggested however that the gendered effects of the reforms were strong: in particular, the effect of shifting much work previously done by nurses to poorly trained social carers and auxiliaries had been to the disadvantage of both low paid women staff and low income clients (Mackintosh 1998, Towers et al 2000). Managerially led reforms have a strong tendency to restructure in favour of the more powerful: gender and social class or status can interact, as institutions change, to the detriment of low income women as both staff and patients.

In much of the world, furthermore, trade unions as a voice for low paid staff are weak. Trade unions have been widely ignored by policy makers, and often actively denigrated and undermined from the 1980s onwards by characterising them as a voice for provider interests which are defined as in opposition to the interests of users. The result is an absence of any counteracting institutional pressure for the rights of staff, exacerbating deterioration of morale and professional ethics. It is a feature of HSR, in both high and low income contexts, that it has been persistently presented by its promoters as a force for change away from services run in the interests of staff to services run in response to patient demand. The evidence is that all too often, this has implied a loss of staff rights to decent working conditions and wages, as recent ILO work on Eastern European health sector reforms has demonstrated (Afford 2003).

A gender 'lens' on reform suggests however a different way of framing these issues. The 'Health Workers for Change' (HWFC) projects, in Africa and elsewhere, have built efforts to improve health care quality post-reform on the observations that the interpersonal aspects of health care – such as respect and ability to listen – are important to quality of care, and that those relational aspects of care are gendered. Female health workers have somewhat different styles of work than men; female health care users have specific needs, and may encounter gender-specific forms of discrimination and abuse (Haaland and Vlassoff 2001, Hartigan 2001, Fonn and Xaba 2001). On these observations the HWFC projects, such as the work of the Women's Health project in South Africa, have built collaborative efforts with health care staff to explore frustrations and shift behaviour in ways that recognise the importance of gender-sensitivity in health care interaction. There is evidence of positive impact on quality of care in four African countries, resulting in part from greater recognition among health workers of the constraints on health seeking behaviour faced by poor women. There was also some evidence of greater confidence of health workers in challenging some aspects of HSR (Onyango-Ouma 2001). The HWFC literature argues that understanding health systems as gendered was crucial to these outcomes.

5. Reproductive health and the gendered effects of health sector reorganization

Question:

Do the organisational and governance reforms associated with HSR improve the health system's capacity to help redress women's vulnerability to reproductive ill health?

Does HSR contain implicit assumptions about women's rights and capabilities, and if so are they defensible?

5.1 Reproductive health as a key aspect of women's health

Vignette 3

This is the experience of a 16 year-old girl from a poor rural family. She was about to complete primary school, but she has not had an easy school life as she was often sent home for lack of school supplies such as exercise books. One day she met a man who offered her gifts and bought her exercise books. In return he wanted a relationship with her. Because she felt she needed his help, the girl accepted and because she knew nothing about contraceptive methods she soon got pregnant. The girl hid her pregnancy because of fear of her parents. Her pregnancy was discovered at an advanced stage and she had to quit school. She went through almost the entire period of pregnancy without attending an antenatal clinic. At the time of delivery she was taken to a nearby health centre, which provided services either to those who were members of a mutual health insurance scheme or to non-members who could pay user fees. Her parents were not members of the scheme and at the time did not have enough cash for the required user fees. There was a delay as the mother rushed back home to borrow the money. The girl had complications during delivery and because of her young age and the delay in being attended she lost the baby. Luckily the girl survived.

Adolescent girls are immensely vulnerable, as the above story shows, especially poor girls caught in the struggle of coping with poverty, the struggle which puts their health at risk in a health system that cannot assure their protection and effectively meet their health needs. Reproductive health remains a key element of women's health. Globally, twenty percent of the burden of disease among women of reproductive age is connected with sex and reproduction. The situation is much worse in SSA, where the proportion is 40 percent (UNFPA, 2002). Reproductive health problems have been compounded by HIV/AIDS. So, to what extent are reorganised health sectors able to respond to this intersection of sexual and reproductive health needs? We address this question in sections 5.2 and 5.3 but first we provide a brief review below of some relevant aspects of sexual and reproductive health.

Essential elements of reproductive health agreed at the International Conference on Population and Development (ICPD) held in Cairo 1994 included: having a satisfying, safe sexual life; access to appropriate, safe, effective, affordable and acceptable methods of family planning based on informed choice and dignity; prevention, diagnosis and treatment of STIs/STDs/HIV; services for safe pregnancy and childbirth; elimination of harmful practices (Female Genital Mutilation (FGM), domestic violence, sexual trafficking); and emphasis on poverty alleviation, girls' education, women's empowerment and reproductive rights . Also emphasized is the role of civil society and community in promoting sexual and reproductive health.

The ICPD provisions notwithstanding, women and adolescent girls continue to face problems related to sexual and reproductive health, which include, among others, uncontrolled fertility, maternal morbidity and mortality, unwanted pregnancy, early child bearing, sexually transmitted diseases including HIV/AIDS, sexual violence, and FGM, which often result in reproductive health related complications. Maternal Mortality Ratio in many SSA African countries remains relatively high. The average MMR for Africa is 1000 deaths per 100,000 live births. This contrasts sharply with the world total average of 400 deaths per 100,000 live births, and the average of 21 deaths for the most developed countries (UNFPA, 2002) Available data show that Africa has one of the highest teenage pregnancy rates in the world (World Bank, 2000b), while WHO puts the number of deaths due to unsafe abortion globally at 80,000 women annually (WHO, 1997). A number of countries in SSA continue to practise FGM.

The patriarchal ideology, which treats women as inferior to men with very little decision-making powers over issues which affect their own well-being also continue to bear heavily on women's sexual and reproductive health. Women face problems ranging from lack of freedom over their sexual lives, which often puts them at risk of contracting STDs as unwilling partners, to lack of resources or say over use of the same on their reproductive and other health needs.

HIV/AIDS continue to cause havoc all over the world and in particular in Sub – Saharan Africa where infection rates remain high. In 2001, SSA alone had 3.5 million newly infected people (UNAIDS, 2002.). Data suggest that generally women have higher infection rates than men. The following data from Tanzania for example illustrates this. Out of the 2,229,770 people aged 15 years and above estimated to be living with HIV in Tanzania during the year 2001, women accounted for a larger proportion (59 percent) than men; in the same year prevalence among females was 13.7 percent and that among males was 10.4 percent. The highest number of reported cases was in the age group 25-34 for females and 30-39 for males.

Data on prevalence and infection rates show that adolescent girls are among the highly vulnerable. In Tanzania for example, prevalence data based on the average of low and high estimates show that females in the age group which include adolescents (15 – 24) had a prevalence rate which was more than twice that of males in the same age group (8.06 percent compared to 3.55 percent) (World Bank, 2003). Another example from Uganda shows a similar picture. Ochieng (2003) cites a World Bank Discussion Paper, which shows that HIV infection rates were growing fastest among Ugandan women aged 15 – 25 years. Considering the circumstances many women and girls in Uganda live in, Ochieng argues that this situation can probably be

projected to today. Both examples show that females are more susceptible to contracting HIV at a younger age than males.

Vulnerability of adolescent girls, in particular those from poor households is compounded by economic hardships, which are themselves exacerbated by the AIDS pandemic as adults die leaving behind young girls and boys to fend for themselves. The vignette focuses an example of how economic hardships make adolescent girls vulnerable to a number of problems including contracting HIV and other STDs, and becoming pregnant at a young age. Indeed Africa has one of the highest teenage pregnancy rates in the world (World Bank, 2000). As data show, teenage pregnancy often results into unsafe abortion (WHO, 1997).

5.2 Service Disintegration and the Loss of Integrated Primary Care

The discussion above clearly shows how sexual and reproductive health issues remain of paramount importance. One would therefore expect that health sector reorganisation would be particularly focused on ensuring that that sexual and reproductive health remain one of the top priorities in health policy, and that HSR improves the extent to which services effectively address the scale of the crisis just outlined.

In the rest of this section we argue that, on the contrary, the approach to sexual and reproductive health within HSR in Africa has been contradictory. In this sub-section, we argue that HSR has been associated with an emphasis on ‘vertical’ provision for some aspects of reproductive health, pulling apart the objective of integrated primary care for women’s and children’s needs that had previously been seen as key to effective provision. In section 5.3 we argue that the counter to that problem proposed within HSR – decentralisation and ‘SWAps’ – has constituted an incomplete response and has brought some problems of its own.

One of the most contested aspects of HSR in the 1990s was the retreat from the policy of integrated primary health care for all, established by the Alma Ata declaration in 1977 (World Health Organization 1978, 2003; Lafond 1995). In its place, the World Bank and other donors proposed a sharp distinction between ‘preventative’ and ‘curative’ care, characterising the first as a ‘public good’ and the latter as ‘private goods’ (World Bank 1993). The World Bank’s approach since that time has been to propose that governments in low (and indeed middle) income countries concentrate on ensuring access to a ‘basic package’ of care, emphasising preventative measures judged to have high cost effectiveness in addressing the main burden of disease. This basic package included some aspects of reproductive health.

This revision of the assumptions embedded in health policy frameworks, effectively narrowed the concept of ‘public health’ as previously understood by its practitioners, changing it from an integrated concept – encompassing equitable public health provision, education and health activism, and primary care and treatment – to a set of specified ‘interventions’ that could be ‘purchased’ and delivered independently (Lafond 1995, Qadeer et al 2001).

This policy shift was associated with two other pressures working against integrated primary care. One was the reluctance of most of the increasingly dominant private

providers to undertake many aspects of preventative care, because it was unprofitable. The other was a strong and continuing preference by donors in the health field for funding 'vertical' programmes, that is, programmes with a specific disease focus, and run centrally under control of the donor. Donors also developed a strong preference for funding preventative programmes, leaving 'curative' programmes to government or fee-supported provision. These donor-run programmes focused strongly on some aspects of reproductive health including HIV/Aids, but operated independently of other provision. Women and men may therefore need to visit different providers for different needs, a source of strain, time loss, confusion and expense.

The result in the 1980s and 1990s was an often criticised disintegration of primary care policy frameworks. In the 1980s proponents of comprehensive primary care criticised the 'selective' primary care embodied in vertical programmes, while donors defended vertical programmes, claiming efficacy and accountability (Rifkin and Walt 1986). In recent years, new funds have been set up to address the crisis of HIV/Aids, and these too have favoured top-down, selective and donor-driven activity. The disintegration of primary care has thus, in many countries, been reinforced. For example, Oliff et al (2003) argue that in Tanzania the government has since 1995 (just a year after Cairo) been actively seeking to integrate reproductive health programmes with each other nationally and at district level, but has met with very limited success. They go on to confirm the renewed pressures in the opposite direction:

The advent of new financing mechanisms, such as the Global Fund to Fight Aids, Tuberculosis and Malaria, brings pressures to establish new vertical management structures and monitoring and evaluation systems, to satisfy contributors' demands for evidence of impact (Oliff et al 2003 p 46).

These issues of integration vs. disintegration are profoundly 'gendered', since, as Section 5.1 argued, women are particularly vulnerable to reproductive ill-health. It is widely accepted that effective and universal reproductive health programmes produce major benefits to women's and children's health, and disintegration wastes resources and undermines access. Yet pleas for dialogue between reproductive health policymakers and campaigners and health sector reform proponents that have been made for many years appear still to be going unheard. (Lubben et al 2002, Tangcharoensathien 2002) As Hilary Standing puts it: 'Health sector reforms have largely marginalised the Cairo agenda' (Standing 2002b p.25).

What then were the (unstated) assumptions concerning gender that underpinned the dominant selective approach within health sector reform? Several commentators identify unstated priorities. Merrick (2002) states that the argument that reproductive health is a basic human right has been dismissed as 'special pleading'. Berer (2002) argues that HSR has been based in a disease-based prioritising of public funding; that there has been insufficient attention to evidence on the effectiveness and social importance of reproductive health care; and that these two aspects have combined with the loss of public sector capacity to provide care and an explicit rejection of sexual and reproductive health rights by ultra-conservative religious movements and institutions to undermine provision for women's needs and the needs of the next generation.

5.3 Effects of Decentralization and SWAps on Reproductive Health Services

A response to these recognised problems of service delivery, within the HSR frameworks, has been a determined push for decentralisation of the management and funding of health care. It was argued that decentralisation allowed local service integration, plus other benefits such as local responsiveness. At the same time SWAp is perceived as a solution to the shortcomings of project-support type of donor funding. Here, we assess the extent to which the two major aspects of this reorganisation of the management and financing of health services - decentralisation and a Sector-Wide Approach (SWAp) to funding – can address sexual and reproductive health needs, including HIV/AIDS. We attempt to examine whether there are challenges to overcome in ensuring provision of quality reproductive health services within the framework of decentralised management and pooled resources for financing priority activities.

A number of studies point out that evidence on the effects of both decentralisation and SWAps on reproductive health services remains scanty not only in Africa, but in other developing countries as well (Standing, 2002a; Ford Foundation, n.d; Lakshminarayanan, 2003). We therefore primarily review what are the possible impacts based on what seems to be the opportunities and/or threats within the two processes.

Decentralisation

The concept of decentralisation as used in this paper refers to a process of devolution of responsibilities for the delivery of services and management of financing and other resources to local government authorities. It was envisaged that devolving responsibilities would enhance transparency, participation and accountability, which would in turn ensure effective delivery of services. However, there is indication of threats to achieving this. We discuss some of these below.

Whether local governments have the capacity to carry out their new obligations under decentralisation has been raised as an issue with a bearing on service delivery outcomes, in this case, health care services in general and reproductive health services in particular. Devolving responsibilities without prior capacity building at local levels as has been the case in some countries is likely to result, for example, in poor planning, priority setting and management of finances. This in turn might adversely affect the capacity of a given local government unit to effectively identify and implement priority activities, including reproductive health services.

Decentralisation is expected, among other things, to increase community participation in decision-making processes. However, experience so far suggests that there is only limited community representation (including women representatives) in decisions which affect their well-being. The implication of this is that often decisions are made without input from the beneficiaries. Given that allocated resources are often insufficient for competing priority activities, from a gender perspective lack of women's voice in decisions could mean marginalisation of reproductive health issues in the setting of priorities. Effective community representation (including women representatives) could ensure that women's needs are taken on board in decisions. There is indeed evidence showing that in some countries such as Bangladesh and India where local women NGO groups have influenced the process, they have

managed to bring women's health needs to the attention of government officials and health care providers (Evers and Juarez, n.d).

The capacity of representatives³ to influence policy, planning and implementation processes has also been raised as an issue to be explored. Representation might indeed not be very effective if representatives lack voice and commitment to be effective advocates of the interests of those being represented. In the case of women representatives, the implication of lack of voice as already noted above, is that women's concerns and needs might be marginalized or even forgotten. Community representatives might indeed lack voice if there is no deliberate effort to ensure that not only do representatives have the capacity to understand and effectively take part in discussions and decision making, but also that they are committed advocates of the interests of those they represent.

Sector_Wide Approaches (SWAps)

Sector-wide financing through pooled donor funds, commonly known as Sector Wide Approach (SWAp), has been introduced in a number of low-income countries with a view to replacing separate project support-type of donor financing, which is perceived to have shortcomings in terms of narrow focus and overlapping services on one hand, and gaps and marginalization on the other. SWAps, which involve governments and donors in the planning and implementation of sector priorities, are seen as a more effective way in addressing sector problems and moving towards more integrated provision.

As noted above, evidence on the impact of SWAps on women's general and reproductive health is still limited. Standing (2002) points out that it is too early to assess the impact of SWAps on reproductive health. Therefore here, as in the case of decentralisation, we primarily discuss aspects of SWAps which are likely to offer either opportunities for, or threats to effectively addressing women's health needs.

SWAps emphasize broad consultative processes with stakeholders in planning and identification of priorities. This is intended to ensure that different stakeholders are able to influence the process. To have a positive impact on gender equity, stakeholder consultations have, first and foremost to be gender inclusive. A key question however is to what degree are civil society representatives including women organisations able to influence policy priorities, in particular at grassroots level? Limited evidence suggests that broad based participation particularly at local levels is weak (Foster, 1999).

Another limitation of SWAps in effectively promoting reproductive health is the "sector" boundaries within which pooled resources are allocated and utilised. SWAps by definition are limited to one sector, in this case health. On the other hand reproductive health components as stipulated by the 1994 ICPD are multi-sectoral. They include issues which are either partly or wholly dealt with by other sectors. For example, issues of domestic violence and harmful practices in different countries are generally dealt with by other sectors. A multi-sectoral coordinated approach in ensuring adequate funding of reproductive health services would thus offer a more

³ For example, in the context of this paper, women representatives on local level bodies overseeing planning and delivery of health services.

effective way of addressing reproductive health issues in a more comprehensive manner.

The criteria used for allocating resources to local governments would also have a bearing on outcomes. Under decentralisation, local government authorities are largely funded by allocations from the central government, which include pooled donor funds. It has thus been argued that if the resource allocation formula does not take into account differences in poverty levels and is therefore not based on need, then local authorities with higher need (those with a poor resource base) would be disadvantaged (The Working Group on Reproductive Health and Family Planning, Center for Health and Gender Equity, 1998). The implication of this is that priority activities including health care services in general and reproductive health services in particular would be inadequately funded. Discussing decentralisation as part of HSR, Standing (2002) notes how poverty of a local area, coupled with accountability mechanisms that are not strong enough to protect essential services can adversely affect basic services provision. On the positive side, however, Goodburn and Campbell (2001) see SWAps' broad-based nature as having the potential for improving reproductive health services, if key outcome indicators such as that of MMR are in place.

As we have repeatedly emphasised, evidence on the impact of HSR on reproductive health in Africa is poor. This absence is profoundly unsatisfactory, given the scale of maternal and child ill health and mortality and the crisis of HIV/Aids, and the disproportionate vulnerability of women. It seems likely that this lack of attention partly reflects a relative lack of capacity of women themselves to exercise leverage over the organisational aspects of health sector reform.

6. Gendered health sector reform meets the labour market: paid work, unpaid work, poverty and a gendered crisis of care

Questions:

To what extent is the context of HSR one of increasingly unmanageable burdens of paid and unpaid work for some categories of impoverished women?

To what extent is HSR exacerbating or relieving those burdens?

6.1. Women's work burden and coping with health needs and demands

Vignette 4

A middle-aged woman operates a stall near her home where she sells fruits and vegetables. She has a husband who is a clerk in a government office and she says life has become so expensive that his salary is simply not enough to meet all household expenses. So she has to operate a small business to supplement his income. She helps in buying food items and paying for her health expenses and sometimes the children's. The woman is also responsible for all the caring and housework at home: caring for her three young children, cooking, cleaning, and fetching water from a nearby well. She has to operate her petty business close to her home because there is no one else to care for the children. All adults in the house are trying to earn some money in one way or another and family members who in earlier days were a safety net in that one could rely on them to take care of the children in the mother's absence no longer stay at home. The woman explains that she is usually very exhausted by the end of the day, while her husband hardly does any housework after he gets home from work. She says however that she has no choice but to struggle on with the business because everything now requires money, including health care and education. She feels overwork is taking its toll on her health

Women now more than ever face high demand on their time as they struggle to bear the increasing burden of both paid and unpaid work. In many developing countries women continue to assume a disproportionate role of unpaid work and care giving in their homes and communities. It has been reported that US\$ 11 trillion or about 69 percent of the US\$ 16 trillion estimated to be missing from the global economy each year was the unnoticed contribution of women in their households and the informal sector (World Bank, 1995). While women continue to disproportionately bear the burden of unpaid work, at the same time economic hardships have led to their increased participation in income generating activities, as the vignette illustrates.

Often seen as an empowering tool, women's participation in income generating activities in low-income countries however to a large extent remains a survival strategy. As the economic crisis and subsequent economic reform programmes escalated costs of basic needs such as food, health care and children's education, many women have been seeking additional means, mostly in low-return income generating activities in the informal sector, to supplement family income (Whitehead 2001).

Paid work as a survival strategy can in turn generate overwork, affecting women's health and increasing their health care needs. The irony however is that income from their low-return activities is often not adequate to cater for their increased health needs, creating a vicious circle. Women's access to health care is constrained not only by the demands placed on their time, but also by their inability to afford quality health services in liberalised health care systems. Because of multiple roles at home and in the workplace, women often find it difficult to allocate time to seeking health care when they are sick.

Also, because of time constraint, women may lack access to information on where they can seek health care, or they might not seek health care if health facilities are located too far or if it takes a long time to be attended. Distance from health facilities has been identified as one of the factors determining access to health services. Also, long waits has been identified as one of the elements of poor quality service, which can discourage people from seeking care at a health facility. For a woman whose time is so constrained with multiple roles, such an element would certainly be an obvious disincentive for seeking care when ill. As already discussed above, liberalisation has contributed to quality problems such as that of long waits as doctors and other medical personnel who are often absent for lengthy periods of time undertaking private practice.

6.2 The crisis of care in the midst of HIV/AIDS and the plight of elderly women

Data on deaths due to AIDS and orphans in Africa are staggering. Data on HIV/AIDS for 2001 show that of the estimated 40 million people in the world who were living with HIV, 28 million or 70 percent were in Africa. Africa also accounted for about 90 percent of the 58,000 children under the age of 15 years who died of AIDS (UNAIDS, 2002). The number of orphans in Africa is also overwhelming. In 2000, out of the global total of 13.2 million AIDS orphans, 12.1 million (about 92 percent) were living in Africa (Africa Action, 2000). Estimates further show that 83 percent of all AIDS deaths in the world have occurred in SSA. The economically active age group of 15 – 49 years is the most affected. As many women and men in the middle generation succumb to the HIV/AIDS epidemic, the elderly are forced to assume new roles of taking care of their terminally ill adult children and subsequent to their adult children's death, caring for their orphaned grandchildren.

The HIV/AIDS epidemic, which confines the sick to long periods of illness and often leads to the death of both husband and wife once one of them is infected, has indeed increased the burden of caring borne by grandparents in many African and other developing countries. Assessing the impact of HIV/AIDS on older people in Africa, a study by WHO (2002) concludes that care for the sick at home and orphans due to AIDS has placed huge burden on the elderly. A study conducted in Tanzania to assess the economic and social impact of HIV/AIDS in the country shows that grandparents constituted the largest category (34%) of carers of interviewed orphans in primary and secondary schools. The grandparents were taking care of as many as eight grandchildren.

A report by HelpAge International and The International Alliance on HIV/AIDS (2003) cites World Bank studies, (Ainsworth and Filmer, 2002; Subbarao and Coury,

2003) which show that in South Africa and Uganda 40 percent of the orphaned children were living with their grandparents, while in Zimbabwe the proportion was more than half. The studies further found that in Tanzania, Uganda and Zambia, grandparents constituted the largest category of carers of orphans. Studies done in other developing countries show a similar situation – grandparents bearing a disproportionate burden in care giving roles due to HIV/AIDS. For example, a study carried out in Thailand (Knodel et al. 2001), shows that about two thirds of adults who were already dead had lived with or adjacent to a parent at the stage when they were terminally ill.

Elderly women constitute a majority of older people caring for sick adult children and orphaned grandchildren, most of whose parents died of AIDS-related illnesses. Traditionally in many countries, the gendered division of labour has been such that the role of domestic work, caring for children, the elderly and the sick has been ascribed to women. The implication of this ascribed role is that in the case of grandparents, the caring role is primarily assumed by grandmothers. The fact that generally women live longer than men also implies a likelihood of there being more grandmothers than grandfathers who could be carers of orphaned grandchildren. Available evidence shows that indeed more women/grandmothers than men/grandfathers are caregivers. For example, in Zimbabwe, two thirds of the 685 older people caregivers interviewed were women. Data from other developing countries show a similar picture. A study in Thailand (Kespichiyawattana and Vanlandingham, 2000) found that women were significantly more likely than men to be reported as personal caregivers and as primary personal caregivers of their adult children suffering from AIDS.

Often in ill health and unable to adequately take care of themselves, elderly women are themselves a vulnerable group expected to be cared for and often financially-supported. Yet, the epidemic robs them of their source of support and care (as their adult children fall ill and later die) and forces them to assume the roles of caring and support themselves. Because of high levels of poverty in many countries in SSA, many elderly people are likely to have experienced poverty throughout their younger lives and are therefore likely to be even poorer in old age. Doubly disadvantaged – by being women and by being elderly, they are among the poorest groups in society, now forced to take on additional burden of caring and raising their grandchildren within the context of decreasing economic means and disintegrating family networks. Taking on additional responsibility of caring for their orphaned grandchildren means struggling to meet food, clothing, health and education expenses for the grandchildren. For most elderly women, in particular poor elderly women this is certainly a heavy burden to carry.

Old age compromises one's health and elderly women's poor health is likely to be exacerbated by their care giving role. The elderly go through physical and emotional stress when taking care of their terminally ill adult children. Furthermore, when taking care of their sick children, the elderly are themselves at risk of getting infected as evidence show that they are not well informed on ways to protect themselves (HelpAge International and The International Alliance on HIV/AIDS, 2003). Elderly women are more likely to be disproportionately affected relative to elderly men because as already pointed out, they are the more likely to be taking care of the sick. After their children die, elderly women might have their health disproportionately

further compromised as they have to struggle to engage in income generating activities to enable them provide the basic necessities such as food, clothing, school fees, uniforms, and health care for their grandchildren. The following vignette illustrates the strain and hardship an elderly woman in a South Western town of Tanzania taking care of orphaned grandchildren endures.

Vignette 5

This elderly lady is a widow, who has seen her two sons die. She is caring for the children of both sons. Her only way of making an income is to buy vegetables, split them up into small parcels and resell them retail. The money is not enough to feed the children properly, nor herself. The children now go to school (since primary school fees were abolished) but cannot come home for lunch because there is no food for them. She herself is weak and sick from poor diet. There will be cumulative effects of poor diet for the children.

Thus the additional burden of caring for the sick and raising orphaned grandchildren is making elderly women even more vulnerable. Time needed for caring, need for resources and the worrying and concern over how to make ends meet are likely to adversely affect their health and subject them to further impoverishment. While this situation suggests need for care and support of the elderly in general and elderly women in particular, provision of care to this vulnerable group remains inadequate. Elderly women are increasingly taking on the burden of care giving and support in the context of an eroding family support system whereby traditionally adult children took care of their elderly parents, and inadequate or total lack of a formal social protection system for the elderly.

The scale of the AIDS epidemic has thus cruelly exposed the inadequacy of the assumptions about women's 'coping' capacity that implicitly underpinned health sector reform: notably that the fees were manageable and the care in the home that reduced the need for payment of fees could be supported by women. The convergence of generalised poverty, fees, high work burdens, ill health of both care givers and care receivers, and the loss of substantial numbers of the economically active population has put a completely unmanageable burden on the shoulders of, particularly, elderly women, with very serious implications for the current generation of children.

7. Conclusions and recommendations

We have shown how factors beyond medical care per se can affect women's general and reproductive health. These include social and cultural factors which adversely affect women's health and overall well-being. Cuttingham and Mynttri (2002) note for example, how the social context of unequal gender relations is central in intervention programmes aimed at promoting safe sex. Since the health sector is, we have argued, itself gendered, that is, it reflects gender hierarchies in its staffing and priority setting, there is a danger that health care that responds poorly to women's needs will reinforce women's broader relative social and economic disadvantage,

undermining for example women's capacity to earn and care for themselves and others.

We have argued that health sector reform has been built on a number of gendered assumptions that have never been made sufficiently explicit. These have included assumptions that women's income, and women's networks of mutual support, were robust enough to find the money for fees; that women's work burdens – including those of elderly women - could be expanded to include more responsibility for care; that the governance structures established for decentralised health system management would properly reflect women's needs; and that women's health needs would not be undermined by the disintegration of primary health care into a mix of vertical programmes and specified 'interventions' associated with the privatisation of much primary care. It is certainly not clear from the available evidence that any of these assumptions was warranted, even before the devastating impact of the HIV/AIDS epidemic.

To the extent that the assumptions are incorrect, poorly designed health sector reforms may not merely ignore issues of importance to women: they may make the position of women, especially poor women, actively worse. Good health care is a key contributor to women's well being; its absence is seriously detrimental, especially in contexts where gender disadvantage and poverty interact with ill health. A discriminatory and inequitable health sector will reinforce other aspects of women's relative lack of rights and dignity in societies that are highly unequal in terms of both gender and social class.

The converse is also true: a health sector that responds effectively to women's needs, and which responds with greater resources to the greater health needs of the poor, can contribute to redressing some of women's relative disadvantage and the extreme deprivation of poor women in many African contexts. What would it take to achieve this?

One essential step, this paper suggests, is much more analysis of the health sector and health sector reform proposals as gendered institutions and gendered institutional change. There has been some good research and activism on this subject, much of it by women in non-governmental organisations and also within governments, but the framework of thought is, we have argued, a very long way from being built into mainstream policy work at national and international levels. As just one further example, the *World Development Report 2004* discusses the 'co-production' of health between communities and health sector staff and its benefits, without recognising (except for one reference to women's support groups) the extent to which such activities are reliant on low income women's unpaid work (World Bank 2004 pp.144-5).

The evidence and arguments surveyed here also suggest policy implications and recommendations for reformers. Here are six propositions.

1. *Design the reform of health care finance in such a way that it does not increase the burden it imposes on the incomes of poor women, and does not increase the relative economic disadvantage of women in general.*

To do this, information is needed on women's access and control over resources in different social and economic contexts; the information then needs to be used in the design of health financing mechanisms.

- 2. Design health sector reform to promote equality between male and female health workers and to improve the working conditions of lower level staff who are predominantly female.*

To achieve this implies rejection of the presumption, embedded in 1990s reform models though now perhaps less widespread, that the interests of staff and those seeking care are inherently opposed, and instead requires attention to the needs of staff, especially lower level staff, as well as patients.

- 3. Involve women equally with men, both as staff and citizens, in health sector reform from the most local to the highest level.*

Women's knowledge and perspectives are essential to achieve policy design that is not discriminatory on gender lines; to draw upon them requires much more involvement of women: from more women in higher level government posts and in health sector management, to women's equal presence in local priority setting and local collaborative efforts at mutual understanding and reform between women health care staff and women residents.

- 4. Do not undertake reforms that increase the work burden of women, especially poor women; instead, design approaches that reduce those burdens.*

To achieve this implies identifying where the worst and most unmanageable burdens are falling, and then not permitting health sector reform dogma to block support directed at those groups. It would also imply campaigning for men to carry a greater share of the burden of unpaid care.

- 5. Build links between reproductive health care and provision for the other health needs of women in ways that reduce the strain upon women of accessing care.*

To achieve this objective would imply investigation of the best way of providing care for women, from women's own point of view, including aspects such as information, time and costs, and then building both national and local services to respond to the findings in different contexts.

- 6. Introduce reforms outside the health sector that strengthen women's rights and status, hence their ability to deal with the health sector on more equal terms with men.*

Strategies to improve women's health have to be considered not only within the medical but also within the social and cultural contexts. This broader context would involve addressing, among other things, issues of women's rights and dignity through supportive laws and policies.

Finally, we have argued that all of these issues have been sharpened and brought to a head for many African women by the HIV/Aids crisis. Let us return therefore at the

end to the predicament of elderly women. Older people's often ailing health is likely to be further adversely affected by the physical and emotional stress of taking care of their terminally ill children and later struggling to support and raise their orphaned grandchildren, and this burden falls predominantly on women. With this taking place within a context of decreased economic means and disintegrating traditional family support systems, it is important that now more than ever that policies and programmes to support the elderly not only as a vulnerable group but also in their role as caregivers be put in place.

Such intervention could take the form of targeting directly provided support, including health care, to families supported and cared for by the poor elderly. There is also need to review the extent to which the contents of paragraph 68 of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS have been implemented. The paragraph states a commitment by 2003 to "to review the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs.....". One implication of this paper is that health sector reform as it is presently designed does not contribute to this objective and appears in some respects to be making the situation worse.

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