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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 at 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