

Globalization Committee  
Reproductive Health Affinity Group

# Globalization, Health Sector Reform, Gender and Reproductive Health



Ford Foundation



The cover incorporates a woven rug, or *lama*, from the Mapuche culture of southern Chile. According to the strict Mapuche esthetic, certain designs are appropriate for men, others for women or for different age groups. This *lama* would be used in the household by the entire family. Its designs represent the Earth, traditional medicinal plants, veins, hearts and human beings.

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This publication was edited by Deborah Meacham, consultant, and designed by graphic artist Marisol Blázquez. Special thanks to them and to executive assistant Mireya Díaz, for their commitment and valuable help in the publication process.



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*by Barbara Evers and Mercedes Juárez*

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# Foreword

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Macro-economic and social reforms influence how households and communities are able to access, generate and sustain assets—the assets that protect people’s security and well-being, and the assets necessary for sustainable human and economic growth. Health sector reforms are an important example, affecting the quality, content and delivery of sexual and reproductive health services. Despite their great relevance to the concerns of health, women’s rights and community advocates, such policy reforms have been undertaken without the informed participation of these activists. Supporting these voices at the policy-making and service delivery levels is a priority of the Ford Foundation.

Since 1998, a group of Foundation Program Officers has promoted awareness of the relationship between globalization and women’s health and rights at the international and national levels. The Foundation has also supported community initiatives to improve women’s access to reproductive health services in the context of health sector reform (HSR); regional meetings to assess the impact of these reforms on women’s health; and regional projects seeking to incorporate gender equity and reproductive health concerns in HSR policy-making, mainly in Asia and Latin America.

The following papers were commissioned by the Ford Foundation’s Reproductive Health Affinity Group (RHAG) to explore how changes in macro-economic and social policies affect women’s reproductive health and rights. In making it more widely available, we hope that donors, policymakers and advocates in the sexual and reproductive health field find it useful in understanding the gender dimensions of sector-wide approaches and health sector reforms.

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The first section of this publication is a concept paper by international consultants Barbara Evers and Mercedes Juárez exploring the interrelationships between globalization, health sector reforms, gender and reproductive health. It focuses on critical issues on the international agenda agreed upon in Cairo (1994) and Beijing (1995) and synthesizes the complex connections between globalization and women's health in a concise and straightforward manner. It also identifies critical areas, barriers and opportunities for sexual and reproductive health grantmaking and advocacy, based on practical experiences and academic research.

In the second section of this publication, Rosalind Petchesky, Rebecca Cook, Priya Nanda and Vimala Ramachandran comment on the economic justice, human rights, assets-building and citizen participation implications of HSR, based on the issues outlined in the concept paper. Their essays complement and contextualize the analysis by Evers and Juárez, suggesting valuable directions for future work in diverse areas of the sexual and reproductive health field.

Gaby Oré Aguilar, Program Officer  
Globalization Committee Chair





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Experts' Perspectives on Globalization,  
Health Sector Reform, Gender  
and Reproductive Health

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## Part I

# Globalization and Health Sector Reform: A Gender Approach

## Introduction

The purpose of this paper is to support the Globalization sub-Committee of the Ford Foundation's Reproductive Health Affinity Group (RHAG) in its thinking about global, macroeconomic, sector-wide influences on women's reproductive health and rights. The work draws its focus from issues identified as important for RHAG and its partners in developing countries. These are to:

- consider the relevance of globalization for women's reproductive health and rights in the context of health sector programs;
- provide a gender analysis of sector-wide programs (SWAPs) and sector reforms examining how reproductive health is defined in sector-wide programs;
- identify mechanisms for bringing reproductive health concerns into the debate on SWAPs;
- identify the barriers and opportunities for bringing a gender perspective to reproductive health in SWAPs;
- consider the best options for protecting and strengthening reproductive health in the context of SWAPs; and
- from this process, make recommendations to the Ford Foundation, its partners and others.

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## 1. The International Context of Health Sector Reform: “Globalization”

Globalization has critical implications for issues which concern advocates of reproductive health and women’s rights. Yet little attention has been given to analyzing the link between global processes and reproductive health. Macroeconomic and sectoral strategies and their implementation which are supported by the World Bank and other donors have yet to fully reflect the findings of academic and policy research which shows that “liberalization and integration processes have been asymmetric and uneven—across countries, classes and genders” (Grown et al., 2000). In this section, we look at the distinctive characteristics of globalization in the current era and explore its relevance for women’s reproductive health and rights in the context of health sector reform.

The concept of globalization is often linked to the rise in predominance of Transnational Corporations (TNCs) and the associated internationalization of production, distribution and consumption. In terms of political economy frameworks, globalization is linked to the “Washington Consensus” of economic development, the cornerstone of which is the liberalization of markets under Structural Adjustment and Stabilization policies of the World Bank and the IMF. Liberalization policies call for the deregulation of world and domestic markets, while placing restrictions on individual country governments’ ability to control direct foreign investment and to influence flows of imports and exports. Therefore, the counterpart of liberalization of markets is the imposition of rules which restrict a country’s ability to use government institutions to protect its own industries (domestic pharmaceutical industries, for instance) and limit the government’s scope for intervening in markets in order to support national priorities.

For the purposes of this paper, globalization is taken to mean the increased integration of national economies stimulated by the liberalization of trade and capital markets (foreign direct investment and financial flows across national boundaries) and rapid technological advances in international communication. In view of current debates about the role of the World Trade Organization (WTO) and the impact of trade liberalization, it is important to emphasize that the expansion in international trade, *per se*, is not the defining feature of “globalization.”

What is “decisively new about the international economy in the late twentieth century” is the deregulation and integration of capital markets combined with profound technological advances which have facilitated the dramatic increase in the pace and decline in the cost of global transactions (Elson, 2000, p.92) and the corresponding restrictions on the scope for intervention by national governments.

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Before looking at what this means for the health sector, it is helpful to identify the important global actors in health sector programs.

### **1.a. Global Actors in Health Sector Programs**

Health sector reform is usually part of a larger package of development assistance (loans and aid) in support of health sector programs in low- and middle-income countries. Therefore, along with the national government bodies which manage and/or deliver health services (typically the Ministry of Finance and the Ministry of Health), a number of external multi-lateral and national institutions are intimately involved in health sector programs.



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These global actors include multi-lateral government organizations of the UN system, of which UNICEF and WHO are among the most active in the health sector. Among the international financial institutions, the World Bank is most heavily involved in health sector programs, usually as lead donor along with a group of bi-lateral donors that includes DANIDA (Denmark), DGIS (The Netherlands), SIDA (Sweden), CIDA (Canada), DFID (UK) and USAID (US).

Transnational corporations are the key global private-sector actors which market drugs and equipment. Rules governing trade and investment (within the WTO framework) make it difficult for a country to use subsidies and taxes to develop its own pharmaceutical and other industries to support the health sector. Smaller, private-sector actors—from outside and, to a lesser extent, within the reforming country—assist governments in capacity building by selling training and consultancy services that are integral components of health sector programs.

The World Bank also plays an influential role in training government officials who are responsible for management and delivery of services under such reforms. In particular, the World Bank's flagship course on Health Sector Reform offers in-depth training on all aspects of sector-wide programs (including reproductive health) to national health professionals and managers.

### **1.b. Structural Adjustment, Globalization and Health: Work in Progress**

Multilateral institutions (the World Bank, the IMF and regional development banks) have become more engaged with classic “social policy” areas of concern—poverty reduction and social protection (ODI, 2000)—since it is increasingly recognized that economic reforms have harmful social effects which may ultimately



*Analyses of the gender dimensions of Structural Adjustment Programs (SAPs) have concluded that gender differences in impact are systematic and not incidental or ad hoc.*

undermine the reforms themselves. Conditions of health provision in many low-income countries have deteriorated due partly to lack of financial resources to repair deteriorating facilities and equipment. This situation has been exacerbated by the demoralization of public-sector workers who have seen their real incomes fall dramatically since the early 1980s.

The gender dimensions of Structural Adjustment Programs (SAPs), including the associated breakdown of social provision, have been analyzed in some depth. One of the central conclusions of this work is that gender differences in impact are systematic and not incidental or *ad hoc* (Commonwealth Secretariat, 1989; Elson, 1991; Afshar and Dennis, 1992). There is still insufficient evidence-based analysis linking SAPs specifically to particular outcomes for women's health and well-being, since, as Hilary Standing (1999) points out, much of the analysis is derived from first principles. Nevertheless, testaments to the increased violence experienced by women in this period are symptomatic of the ways in which the burden of adjustment has been felt most acutely by women.

There is even less evidence-based analysis of the gender dimensions of globalization. As yet, there has been little multi-country analysis of the linkages among globalization, health sector reform, and women's health and reproductive rights. However, a few ongoing studies may provide helpful insights although their results generally have not been made available. One of these studies is funded by the Canadian organization, the International Development Research Centre (IDRC). This multi-country investigation attempts to draw linkages among macroeconomic reforms, sector reform and health. However, the gender analysis in the research proposals seems weak, so it is not yet clear what sort of results this study will produce (IDRC, 1998).

Medac, a UK-based organization, is currently managing a large study of the impact of health sector reform on health in a number of developing countries. Again, the gender analysis in this study is not strong. A more promising prospect is the work proposed by the Center for Health and Gender Equity (CHANGE) in the United States (*see Appendix 1*). Building on the work summarized in the 1998 CHANGE and Population Council Report, CHANGE is about to begin a multi-country study (India, Kenya, Mexico, Zimbabwe and either Uganda or Tanzania) which looks specifically at the effects of health sector reform on reproductive health outcomes. This project will also incorporate support for advocacy to strengthen women's reproductive rights and health.

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A number of international NGOs—Oxfam and Action Aid, for example—are looking at the impacts of WTO rules on availability of medicines in developing countries. Other initiatives—such as the Women’s Health Project, in Johannesburg, South Africa (*see Appendix 2*)—are also pertinent to the concerns of RHAG.

The connections between globalization and women’s reproductive health and rights are not straightforward, and as yet, there is little systematic evidence exploring these linkages. The following paper will examine more closely what is meant by globalization and attempt to analyze its broad implications for women’s health and well-being, albeit largely from first principles.

### **1.c. Globalizing Influences**

A recent collection of academic papers (partly funded by the Ford Foundation) examines the gender dimensions of globalization. It is argued that “...increased integration is accompanied by trends toward social fragmentation, disintegration and localization... [L]iberalization and integration processes have been asymmetric and uneven—across countries, classes and genders” (Grown et al., 2000, p.1146).

While there are clearly significant negative social developments associated with globalization, tracing the links from globalization to women’s health and reproductive rights is not at all straightforward. This effort requires a clear methodology and adequate data and must be context specific. It is beyond the scope of this paper to assess the influences of globalization on health outcomes and, specifically, on women’s reproductive health and rights. However, to begin to make sense of the gendered effects of global processes, it is useful to examine certain aspects of globalization which influence the national setting in which health sector programs are delivered. Here we identify three dimensions of globalization and explore their implications for women’s health and rights in the context of health sector reform: i) increased women’s employment and lower labor standards; ii) the “squeeze on care” and; iii) the deterioration in human and social capital.

#### **(i) Increased Women’s Employment and Lower Labor Standards**

It is commonly argued that national governments attract foreign investment through competitive reductions in labor rights and labor protection and by reducing taxes on foreign enterprises. At the same time, it has been established that in many countries—



*Women's lack of decision-making power in all spheres of life undermines efforts to strengthen women's reproductive health and rights. Multi-pronged approaches to supporting women's human rights in all spheres...need to take a more prominent place in advocacy and policy strategies.*

particularly in Latin America and parts of Asia and Eastern Europe—increased foreign investment and expansion of trade is associated with a feminization of the labor force (Standing, G., 1989, 1999). While women may gain from new and often more lucrative sources of income, there is also a downside: deregulation of investment and conditions of production have led to worsening labor conditions, including increased casualization of employment.

For example, the expansion of horticultural exports in Latin America and Africa, where the labor force is largely female, may bring higher incomes for women workers but also exposure to new health hazards and an increased workload (see Hale, 1999 and references therein). “Work is as much a part of women’s life today as is marriage, pregnancy and motherhood” (Messing, 1998, p.138).

The nature of employment in a globalizing world provides a forceful example of the linkages between women’s rights and health in the workplace. In this context, women’s rights are clearly undermined through prohibitions on collective and/or union activity, mandatory pregnancy tests and restrictions on lavatory use. Poor factory conditions—such as bad lighting, hazardous chemicals and dangerous machinery—and outright abuse of women is common. Work is often physically arduous, and women are exposed to oppressive and dangerous treatment, including sexual harassment and rape. Nevertheless, protecting women’s reproductive health and rights in their role as workers—in the health sector or elsewhere—is rarely discussed in the context of global social policy, health sector reform or reproductive health strategies.

Notions of “vulnerability” and “equity” in health sector reforms do not take into account the threat to women’s reproductive health which is posed by these new forms of employment. Public-sector expenditure increasingly is directed to supporting and “facilitating” private-sector development and export-led growth, yet government does little to support the well-being of women workers in export-oriented industries.

A second point to make in relation to changing conditions and structures of employment is that they affect differently the ability of men and women (as well as boys and girls) to use and pay for health services and drugs. In some cases, as women’s cash incomes rise, responsibility for paying education and health fees shifts away from men to women (CEEWA, 1995). Elsewhere, a rise in cash employment for women has brought greater autonomy within the family but at the cost of worsening health and greater time burdens for female wage-earners. It is also important to note that increased time burdens may mean that women are less able to

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exercise their rights as citizens because they simply do not have the time to participate in civil activities.

### **Women’s Reproductive Health and Rights and Decision-Making Power**

It is often men and not women (and especially not younger women) who make decisions about household expenditure, regardless of who earns the money. Social norms, which tend to favor boys over girls and men’s well-being over women’s, influence patterns of household expenditure which can act against girls’ and women’s interests (Dwyer and Bruce, 1985). This is one expression of a more profound and deeply-entrenched problem of society-wide undervaluation of women and girls which cannot be rectified simply through provision of relevant services. Women’s lack of decision-making power in all spheres of life undermines efforts to strengthen women’s reproductive health and rights. Multi-pronged approaches to supporting women’s human rights in all spheres—including the right to adequate primary health care, housing and social security—as well as strengthening women’s rights in law, employment, education and political life need to take a more prominent place in advocacy and policy strategies.

### **Putting Women’s Rights on the Agenda**

While women’s rights to freedom from violence in the home, the workplace and all social settings should form a central plank of the human rights agenda, “until very recently international human rights organizations focused almost exclusively on the investigation and reporting of violations of the civil and political rights against men... rather than on the equally serious abuses that are perpetrated against women in less-public settings” (Boland, Rao and Zeidenstein, 1994).

### **(ii) The Squeeze on Care**

The 1999 UNDP Human Development Report argues that “intensified competition has tended to squeeze the resources available for the provision of care, including not only unpaid care, but also care services provided through the public and private sectors” (cited in Grown, et al., 2000). It is argued that the deterioration in conditions of care which is associated with globalization can occur through three channels—in the public, private and unpaid, domestic sectors—as detailed on the following page.



## The Squeeze on Care

Globalization is associated with a squeeze on resources devoted to care in the public, private and unpaid domestic sectors:

- **a squeeze on unpaid time** (mainly women's) which would normally be spent providing for families and communities as women allocate more of their time to paid work;
- **a squeeze on publicly-funded care** as public-sector spending is cut in response to an increasingly competitive international economic environment which restricts many sources of revenue (trade tariffs, taxes on foreign investors) previously available to governments to fund publicly-provided care services; and
- **a squeeze on the quality of care in private-sector services** due to competitive pressure to cut costs.

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*Source: UNDP Development Report, 1999.*

These three points depict a more holistic picture of cuts in resources going to care. It is not simply government services which are being squeezed, but another essential “input”: women's time. The squeeze on care has broad implications for women's health and rights in the context of health sector reform (a point made above in relation to employment and globalization). In turn, the under-valuation and under-resourcing of care, which is primarily women's domain, tends to undermine women's rights as citizens and legitimate members of society. Women's ability to act as citizens “continues to be constrained by their responsibilities in the private [sphere] with implications too for the rights they enjoy as citizens” (Lister, 2000, p.99). Women's caring responsibilities are time consuming and often arduous, factors which tend to restrict women's access—far more than their male counterparts—to the full benefits of social, political and economic life. At the same time, there are other social implications of this squeeze on care related to the deterioration of social capital.

### **(iii) Deterioration in “Human and Social Capital” Generated by Households**

The rapid expansion of world trade and international financial flows, combined with their deregulation, have generated instability and increased risk in national economies, as the East Asian crisis has illustrated. It is argued that as a consequence of globalization there has been a tendency to shift the risks of global production from individual firms in the private sector to households and communities in the “domestic sector” (Elson, 2000, p.93). Households may be equipped to deal with increased risk only under



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economic growth.*

certain conditions: where economic growth is strong and stable and employment is high; where there is a strong base of human, social and physical capital; and where political entitlements are extensive and strong (Elson, 2000). However, in the absence of such conditions, the household is unlikely to be able to bear the risks associated with globalization.

Clearly social stability and strong community networks make positive contributions to social and economic development. Yet the significance of women—mothers, grandmothers, eldest daughters—as the main providers of home-based health care and preschool education or inter-family support is rarely discussed in policy circles (see Elson and Evers, 1998). By recognizing the different dimensions of the squeeze on care, the UNDP draws our attention to a significant gap in recent theorizing about human and social capital. While the concept of human capital may be helpful by bringing into focus the importance of human beings and their levels of education and health as determinants of economic growth, it is rarely acknowledged that health and education are not simply “purchased” in the market or provided by public sector institutions. Rather, health and education depend on women’s unpaid labor in the home and in community activities which underpins the “variety of intangible social assets (that mainstream economists now like to call ‘social capital’)” (Elson, 2000, p.80).

The evidence on adjustment gathered by feminist analysts in the 1980s and early 1990s documents the fact that, within family and community structures, women have tended to try to cushion the blow of economic adjustment (Afshar and Dennis, 1992; Beneria and Feldman, 1992). However, it is simply not sustainable to rely on the goodwill of individual women to deal with the profound society-wide costs of economic adjustment. Vandermoortle (2000) points to the more recent experiences in East Asia where the countries that were hardest hit by the financial crisis were also the ones lacking specific policies to act as “social shock-absorbers” and where the foundation of such shock absorbing is actually provided overwhelmingly by women.

Shifting the risks of globalization to the household leads to the deterioration of “social capital” (social well-being and cohesion) and undermines the conditions for replenishing the resources that maintain the security and well-being of people in households and communities. Ultimately, it undermines the prospects for sustainable economic growth.

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“When people have to live from hand to mouth, human energies and morale are weakened; ‘contingent labor’ is conducive to ‘contingent households’ which fragment and disintegrate, with costs for the people from those households and for the wider society” (Elson, 2000, p.94).

It is ironic that at a time when the importance of skill formation, development of human abilities and competence have re-emerged at the center of debates about development, in practice the experience of globalization is increasingly undermining our abilities to enhance such development. The trend of globalization has been to generate greater insecurity in economies which are affected by huge shifts in capital flows which in turn can create greater household risk and hence insecurity (see Floro and Dymski, 2000). This often takes place in a context of fiscal conservatism and where public expenditure priorities are more likely to reflect the needs of short-term financial markets than of human development (Elson, 2000). This approach ignores possibilities for integrating gender equality and the strengthening of women’s rights into economic policy. Developing an alternative, more human-centered approach would require economic and social policy analysts to recognize and actively integrate into their strategies the understanding that the economy as a whole is dependent on the output of the household and community sector, which is largely maintained by unpaid female labor.

### **Reducing Gender Bias in Access to Social Capital Assets**

Alongside the need for stronger rights-based approaches to women’s health, feminist economists and some policymakers have demonstrated strong economic justifications for strengthening women’s reproductive health and rights and social well-being. For instance, the 1998 World Bank Report, the *Special Programme on Africa (SPA) Status Report* on poverty in sub-Saharan Africa, argues that for this region to achieve equitable growth and sustainable development, it is necessary to reduce gender inequality in access to and control of a diverse range of productive, human and social capital assets. These include reducing gender inequalities in participation and strengthening women’s voices at household, community and national levels.

Blackden and Bhanu’s (1998) analysis of public policy in sub-Saharan Africa highlights the significance of power gaps between men and women within the household for economic decision-making and resource allocation and in the area of fertility and contraceptive use. Their World Bank Report emphasizes that



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*Greater gender equality in access to social assets is a component, not only of sustainable growth, but of an effective reproductive health strategy.*

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“women’s ability to negotiate decisions that affect fertility depends in part on their access to independent income and the choices that are created through literacy, numeracy and formal education. This becomes especially important in the context of the growing AIDS epidemic.” (Blackden et al., 1998).

Thus, greater gender equality in access to social assets is presented as a component, not only of sustainable growth, but of an effective reproductive health strategy.

## **2. Sector-Wide Programs and Reproductive Health: A Gender Analysis**

### **2.a. Standardization of Health Sector Reforms in Sector Investment Programs**

In the aftermath of the “decade of adjustment” (1980s), we see the “standardization” of “health sector reforms” across diverse countries/regions. For low- and middle-income countries, sector reforms are a central component of multi-donor-supported sector investment programs (SIPs), or Sector Support Programs, which are increasingly referred to simply as SWAPs (Sector-Wide Approaches).

Whereas structural adjustment emphasizes the importance of “getting prices right,” sector program support is more focused on “getting institutions right.” Sector-wide strategies represent a shift from separately-financed, individual-project-based approaches to financing health to a more integrated, sector-based approach. Sector-wide programs consist of two related elements: the lending instrument (coordinated finance agreement between government and donors) and the integrated sector strategy and its associated outputs. The focus of this paper is on the second element, which we refer to as a SWAP.

SWAPs present both opportunities for and threats to strengthening women’s reproductive health and rights. As yet, there is not sufficient evidence to judge the balance in outcomes. Here we provide a general discussion of particular aspects and tendencies associated with SWAPs.

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## Core Components of Sector Program Assistance

The components of sector program assistance are agreed through extensive negotiations among donors themselves and between the recipient government and the donor consortium. These core components are summarized below:

- Donor assistance and ministry finance are pooled into one coordinated sector program rather than a series of separate donor projects.
- A sector-wide strategy is formulated and implemented by the Ministry of Health on the basis of extensive consultation between ministry officials, all donor partners and stakeholders.
- A common budget and accounting framework, common procurement arrangements and joint review procedures for sector program activities are established.
- Local capacity in the management and delivery of health services is strengthened.
- Government sets up systems to ensure more effective and accountable resource utilization.

Most countries undergoing SWAPs have a history of structural adjustment where cuts in the public sector deficit have been a central feature. A common starting point, therefore, for many SWAPs and the associated health sector reforms (HSR) is “tight” or constrained public-sector financing. This partly explains the emphasis within HSR on developing alternative sources of finance and streamlining the sector to provide “basic,” “essential” or “core” services to meet the needs of the poor and vulnerable. Without improvements in quality and patterns of service delivery, cuts in health expenditure are unlikely to strengthen women’s reproductive health—especially where public-sector interventions have been shown to have a positive impact. However, in view of the poor targeting of health expenditure in the past, one cannot say with certainty that a decline in health expenditure will necessarily result in worse health outcomes. For instance, if cuts in expenditure by the Ministry of Health are accompanied by an increase (or better targeting) in investment in sanitation, particularly clean water, and this results in increased access to clean water among the poor, the outcome for women’s reproductive health may actually improve.

In many ways SWAPs are a “continuation of several elements of the classic HSR agenda, notably reforming health management systems and ministries of health and setting clear priorities for the public sector” (Standing, H., 1999). However, certain aspects of sector-wide programs represent efforts to learn from past mistakes. For instance, the strong emphasis on government ownership represents the attempt to avoid the pitfalls of “conditionality” associated with



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*Despite the standardized format, in practice the priorities and content of the sector strategy vary among countries and regions. These reflect their very different situations on the ground but also the degree to which sector reform is donor-driven.*

Structural Adjustment Programs. Secondly, donors' desire to improve the coherence of their own aid programs means they may be more willing to "pool" funds rather than finance numerous uncoordinated, individual projects. The shift away from projects aims to streamline the administration and ease the burden for recipient governments. Thirdly, the strong emphasis on capacity building in sector-wide programs represents an attempt to strengthen public-sector institutions, many of which deteriorated considerably in the 1980s.

The blueprint for sector-wide programs—originally described by Cassels (1996) and later amended on the strength of experience—is described on pages 23-24 of this paper. However, as most authors point out (Standing, H., 1999; Elson and Evers, 1998), the gap between reality and the "ideal" remains wide—an important reason for looking at specific SWAPs to identify the best way to influence the process. Despite the standardized format, in practice the priorities and content of the sector strategy vary among countries and regions. These reflect their very different situations on the ground, but also, it is argued, the differences reflect the degree to which sector reform is donor-driven (Standing, H., 1999).

At the heart of HSR in many Asian countries is the integration of relatively well-financed family planning with less well-supported health wings, which entails the integration of two separate accounting, management and delivery structures. In principle, the integration of services is considered a positive step for strengthening women's reproductive health. However, some of the evidence so far suggests that institutional reform has hurt women providers and benefited male health providers (Standing, H., 1997).

For Latin America, which is relatively industrialized and urbanized in comparison with other regions, health sector reform is focused largely on two sets of institutional changes: decentralization and social security reform (Standing, H., 1999). In Africa, sector reform is taking place in a much weaker institutional and economic environment and where the impact of HIV/AIDS is relatively widespread and profound. Here, the emphasis has been on developing different financing mechanisms for the sector and in capacity building in human resource development and management (Standing, H., 1999). Thus, the extent to which SWAPs pose a threat to women's health and reproductive rights depends on the effects of these regionally distinct changes. For instance, institution-building in sub-Saharan Africa may strengthen governments' ability to supply better quality primary services and reduce corruption and raise confidence in the public sector. On the other hand, women may become even more disadvantaged by decentralization and gender-biased social security reform in Latin

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America. Only case studies at the country level and below can provide definitive answers.

## 2.b. Institutional and Management Aspects of SWAPs

The existence of severe limitations on national public-sector resources is normally the starting point for a SWAP. The institutional objectives of health sector reforms, therefore, are to provide the most effective, relevant, well-managed and professional health service possible to the population. Once the sector strategy is identified, the gap between national resources and the actual costs of delivery is identified and donors are requested to fill the gap. In return, the government must demonstrate that the strategy can be implemented and sustained. For these reasons, emphasis is placed on reform of management structures and systems of accountability (largely financial).

In view of some problems of structural adjustment programs (SAPs)—namely, lack of “ownership” and slippage (failure to implement reforms)—the focus for SWAPs is on building a good relationship with the recipient country and anchoring ownership. Therefore, early negotiations over the nature of the sector program are lengthy and involve extensive consultation and “capacity building” within government organizations. As part of the drive to strengthen ownership, sector programs usually emphasize the need for wide consultation with stakeholders and strengthening accountability to beneficiaries. As yet, there is little evidence of systems of accountability to users in formal management structures.

An important gap in the sector-wide approach is the lack of communication with community groups, locally-focused NGOs and women’s health groups. SWAPs themselves would be strengthened by adapting a stronger, more effective and accountable method of stakeholder participation. The most appropriate ways to channel community voices into the sector process will depend on the country context. For instance, in Bangladesh, a women’s NGO *Naripokkho* has brought together women and local government officials to discuss women’s unmet health needs which has proved to be an effective way to bring women’s concerns to the public health providers. In India, women’s community health groups have had some success by focusing on lobbying and informing the World Bank representatives (refer to Healthwatch Trust, India, for instance, *see Appendix 4*). In South Africa, the Women’s Health Project has supported participatory training with nurses which has improved quality of care to poor women while other initiatives of the Women’s Health Project focus on improving the accountability of public expenditure through work on the budget process in South Africa (*see Appendix 2*).



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*SWAPs themselves would be strengthened by adapting a stronger, more effective and accountable method of stakeholder participation.*

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Policy-level initiatives (such as the Women’s Health Project, South Africa) address the lack of transparency of sector programs—few community groups have access to information. Indeed, many primary health workers themselves know little about health sector reforms and new health sector strategies. The “people’s right to information” movement in India is an example of a direct approach to improving transparency of local government.

### **Health Sector Reforms in the SWAP**

Health sector reforms are normally a central part of a health sector program. Their aim is to improve accountability, efficiency and transparency in the sector. While there are differences among donors in the relative importance and precise specification of particular reforms, they are usually incorporated in some way into health sector programs. The components of health sector reforms are summarized below.

#### **Health Sector Reforms consist of:**

- Implementation of new public management systems;
- Reorganization of the health ministry linked to overall reform of the public sector’s budgeting, accounting and planning systems;
- Decentralization of sector activities, including local ownership and accountability for the planning and/or management of service delivery; decentralization of financial management;
- Improving stakeholder participation and accountability to primary stakeholders;
- Introducing alternative financing mechanisms, including contracting out of services to the private or NGO sector, user fees, social and private insurance schemes, and privatization of drug marketing.

#### **Core Services in Health Sector Programs are:**

- Family planning and reproductive health (includes nutrition and prevention and treatment of sexually transmitted diseases);
- Child health;
- Communicable disease control; and
- Some curative service provision.



### **Reproductive Health and Family Planning Services normally include:**

- Family planning, with a central focus on supplying contraceptives to women;
- Insufficient attention to men, issues of choice and dignity of women;
- Limited prenatal care; and
- Emergency and essential obstetric care.

Compare this with the essential elements of reproductive health agreed at the International Conference on Population and Development (Cairo, 1994):

### **Essential Elements of Reproductive Health as Defined by the ICPD Programme of Action:**

State of complete physical, mental, social well-being consisting of:

- Satisfying, safe sexual life;
- Access to appropriate, safe, effective, affordable, acceptable methods of family planning based on informed choice and dignity;
- Services for safe pregnancy and childbirth;
- Prevention, diagnosis and treatment of RTIs/STDs/HIV;
- Elimination of harmful practices (FGM, domestic violence, sexual trafficking); and
- Emphasis on: poverty alleviation, girls' education, women's empowerment and reproductive rights as core, and the role of civil society and communities.

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*Source: Adapted from Joan Kaufman, Overhead, Regional Ford Foundation Meeting on the Gender and Reproductive Health Impacts of Health Sector Reform, Yunnan Province, China, March 12-17, 2000.*

### **Sector-Specific Government Machinery Drives Sector-Wide Programs**

From the perspective of women's reproductive health and rights, sector-wide programs are constrained by the way in which the sector is defined operationally. Because the Ministry of Health drives the process and financial flows and because reforms are ministry-specific, the importance of water, sanitation, transport and education for women's reproductive health and rights cannot easily be institutionalized in a SWAP. However, there are some exceptions. The Pakistan Social Action Plan, a multi-donor social sector program, is an example of a cross-sectoral program which incorporates primary health care, primary education and sanitation into a sector program support initiative (Elson and Evers, 1998).



*Targeting poor women to strengthen reproductive health and gender equity is partial and ineffective as a tool of gender-aware health strategy.*

## 2.c. The Private Sector in SWAPs

Formulation of the sector framework normally involves redefining the public and private responsibilities within the health sector. This may result in recommendations for the privatization and regulation of certain health sector activities, such as the marketing of drugs; provision of certain types of services; creating a better working environment for private service providers by providing training and improvements in social and physical infrastructure; or promoting competition in the sector through deregulation of some markets (Elson and Evers, 1998). It might also involve subcontracting certain services to NGOs or the private sector.

While the scope of the sector normally includes public and private providers in the formal and informal sectors, there is no explicit consideration of the role of households in health provision (Elson and Evers, 1998). The household forms part of the sector only as a consumer of services, and gender differences within the household are largely ignored. Although the central role of women as providers of household and community health care is emphasized in general health sector and WID (Women in Development) documentation (see DANIDA, 1988; CIDA, 1996), this information is not yet integrated into sector program support operations.

### Women, Work and Reproductive Health

“Fishermen’s wives clean the fish to be preserved when catches are abundant... This work has to be done without delay on a daily basis to prevent the fish from spoiling. Women are very much aware that their breastmilk goes down when they work hard and don’t take time to eat and rest properly, but they have to manage these conflicting obligations somehow. Nutrition messages must take into account the circumstances of women’s lives and not assume that all mothers have only one job to do: look after their children” (Blanchet, 1991, p.38).

Most health sector program support is directly channeled to public provision of basic or “essential services” targeted to the poor. The Bangladesh example is common, where the health sector program calls for the allocation of the bulk of public expenditure to primary health care, providing an essential package of services (EPS) and encouraging the private sector to take over some urban-based hospital services which are considered “non-essential” and tend to be used by higher-income groups.



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*The targeting approach shows little appreciation of the ways in which gender inequalities have an impact on the causes of poor health among the population as a whole.*

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### **The “Targeting Women” Approach Fails to Address Society-Wide Gender Inequalities**

Most sector programs “target” poor women to strengthen reproductive health and gender equity in health. However, the targeting approach is partial and ineffective as a tool of gender-aware health strategy (Elson and Evers, 1998; Gilson, 1998). For instance, gender disaggregated indicators may show that most health clinics do not have women doctors, so gender-specific policy components may target expenditure for training more women doctors. However, without addressing the special problems women face in finding the time and/or money to travel to and from a clinic—regardless of the presence of a female doctor—women’s needs will not be adequately met. In a report for UNICEF, Vandemoortele (2000) concludes that narrow targeting of services to the most needy is likely to yield savings that are “penny-wise but pound-foolish.”

By relying on better targeting, health sector reforms do not consider the ways in which gendered norms pose particular difficulties for women providers and users—such as the problems faced by women doctors in re-locating to rural areas or women’s tendency to undervalue their own health needs in comparison to those of their children and husbands.

Broadly speaking, targeting does not take into account the sector-wide and society-wide gender inequalities that influence women’s reproductive health status, women’s access to reproductive health services, and gender inequalities and gender bias in human resource management which have a strong bearing on the quality of care in reproductive health service delivery (see Standing, H., 1997, 1999, for a gender analysis of the human resource aspects of HSR). The targeting approach shows little appreciation of the ways in which gender inequalities among both providers and users of health services have an impact on the causes of poor health among the population as whole. Some donors take these points on board. For instance, CIDA policy notes that “women are the main caregivers for all the family; empowering girls and women through community development and access to education is the key to social and economic development, and the health of children, families and communities.” (CIDA, 1996, p.5, cited in Elson and Evers, 1998). Yet the design of services and training which reflects this understanding tend to be absent from the implementation stage of sector programs.

### 3. The Experience of Reproductive Health in SWAPs and Sector Reforms

Health sector reforms have been criticized for failing to fully support women's reproductive health and rights (CHANGE and Population Council, 1998). Why is this so? In practice, reproductive health services tend to focus on family planning, limited prenatal care and obstetric care and to cover interventions in women's child-bearing activities. Some programs include a minimum of counseling and gender training. Adolescent girls' and especially older women's health tend to be marginalized in SWAPs. In practice, the relevance of men in reproduction is barely reflected in reproductive health priorities.

#### Weaknesses in SWAPs from a Gender Perspective

- Failure to take into account the effect of gender inequalities on women's and girls' health;
- Low priority given to the rights, needs, dignity and privacy of women;
- Systematic lack of sensitivity to women's preferences and needs in the design and construction of maternal health centers and public health clinics;
- Insufficient priority given to malnutrition among young girls;
- Insufficient importance placed on gender-biased attitudes of service providers;
- Failure to take into account the effect of women's work on their reproductive health.

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*Sources: Blanchet, 1991; Ramachandran, 2000; CHANGE and Population Council, 1998; Regional Conference Lijiang, Gender Issues Office, Ministry of Health, Bangladesh, 1999.*

On the basis of evidence so far, “[r]eproductive rights and gender equity concerns have not yet become a central part of the health sector reform discourse nor a central focus of implementation...” (Jodi Jacobson, 1998, p.2). As yet, sector reforms seem to stimulate very little investment in primary and preventive reproductive health other than contraceptive delivery (CHANGE and Population Council, 1998, p.1).

In India, “HSR...is more about macro policy changes related to contracting out services and formation of corporations and autonomous bodies... The government has primarily experimented with contracting out services for laundry, hospital food, cleaning,

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etc. There is talk about health insurance, community-based group insurance linked to savings and credit, opening the insurance business to multi-national corporations... With the exception of a corporation for the supply of drugs in Tamil Nadu, we have made little progress in this area. Health sector reforms are today limited to insurance, privatization and user fees. Even the quality of care issues raised in the reproductive health program has not found its way into HSR!” (Ramachandran, 2000).

## Implications of New Forms of Cost Recovery

### *Insurance*

The evidence suggests that private insurance puts women at a disadvantage in terms of costs and impacts. Insurance risks are structured so that women, and not society as whole, bear the financial costs of reproduction. Under most private insurance schemes, either childbirth is not covered, or women pay a higher premium than men. For instance in Chile, “a young, unmarried, healthy male professional is in a position to gain access to a much higher level of insurance than he needs, while a mother herself must bear the cost of increased risk associated with maternity care” (PAHO website, <http://www.paho.org>, see also Appendix 3).

In India, Ramachandran (2000) points to evidence that the use of private health insurance has resulted in higher rates of cesarean section and hysterectomy without valid medical indications. The Health Economics Unit in the Ministry of Health Bangladesh is currently exploring the gender implications of various forms of insurance. Evidence should be available by 2001.

A key issue for health sector reform is the on-going debate on the desirability of various forms of insurance schemes to finance essential health and particularly expensive tertiary interventions such as cesarean sections. The issue of micro-finance for health is particularly important and timely and needs to be considered in light of a gender perspective on women’s reproductive health and rights. Although some analysis of the implications of various health insurance schemes is being undertaken in Bangladesh by the Policy Research Unit, a more systematic analysis with input from women’s health and community groups on the experiences of micro-finance for health is needed.



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*Health sector reforms have been criticized for failing to fully support women’s reproductive health and rights... In practice, reproductive health services tend to focus on family planning and limited prenatal and obstetric care...*

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### *User fees*

There is sketchy evidence on the gender impact of user fees, most of which comes from sub-Saharan Africa. Hilary Standing (1999) cites evidence that in Nigeria user fees were associated with a 56% rise in maternal deaths and a 46% decline in hospital deliveries in the Zaria region (from Ekwempu, et al., 1990) and a decline in the use of maternal and child health services in Zimbabwe in the early 1990s (from Kutzin, 1995).

A review of the theoretical arguments and empirical evidence regarding user fees to finance basic social services draws very negative conclusions. For the health sector in general, it found that:

- user fees do not guarantee greater efficiency and effectiveness;
- the market does not necessarily work for health sector services;
- user fees collect very modest amounts of money compared with the budgetary resources allocated to basic social services;
- user fees lead to a reduction in the utilization of services, particularly among the poor;
- protecting the poor is difficult because exemption schemes seldom perform well and are costly to administer; and
- user fees tend to aggravate gender biases, seasonal variations and regional disparities (Reddy and Vandemoortele, 1996, cited in Vandemoortele, 2000).

However, it must be remembered that “free at the point of delivery” public health services are rare. For most people in low- and middle-income countries, the use of public services involves a cost in terms of transport, time, unofficial fees, provision of bedding and food, etc. Many of these costs are borne by women. In most poor countries, the majority of people rely on the private sector, either formal or informal, to treat many illnesses, and the public sector is often the least used health service. Therefore, establishing the effects of user fees involves taking several factors into account, including for example, the extent to which fees replace informal costs or whether women are simply switching from one fee-paying service (informal or formal private) to another (formal public).

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## 4. Options for Protecting and Strengthening Reproductive Health in the Context of SWAPs

### 4.a. Global Movements for Health Sector Reform: The Need for Strategic Alliances

It has been argued that “there are two important streams pushing for reforms within the health delivery system across the world” (Ramachandran, 2000). The two powerful lobbies consist of one backed by the World Bank, major bilateral and multilateral donors and another (catalyzed by ICPD and Beijing) by international foundations and NGOs (Ramachandran, 2000). However, their positions are not always polarized, particularly when one takes into account the role of national governments in the health sector. Experiences in the Asian region show the importance of strategic alliances. In India, for example, strong lobbying of the World Bank by women’s health NGOs helped to shift the government to a more positive approach to reproductive health (Kunming Medical College/Ford Foundation, 2000). In Bangladesh, women’s NGOs and supportive individual consultants have successfully worked with bi-lateral donors—most notably the Dutch and the Canadians—to help to integrate ICPD objectives and a more gender-equitable approach to the health sector program (Evers and Kroon, 2000).

Sector-wide programs are not necessarily incompatible with the objectives of Cairo and Beijing or the aims articulated by global movements for strengthening women’s reproductive health (see CHANGE and Population Council, 1998). In theory, sector-wide programs are meant to support greater equity in the design and delivery of health services. Providing better, more appropriate and accessible services to women and the poor is usually a guiding principle of sector-wide programs, and reproductive health is usually a key element of the essential package of publicly-provided “core” services.

Policy guidelines for SWAPs usually contain commitments to advance gender equity and, in some cases, to promote women’s empowerment. SWAPs are meant to be “demand-oriented” or “results-oriented” and to reflect stakeholder participation, where stakeholders include men and women, medical and non-medical staff as well as the ultimate beneficiaries of health sector services.

The World Bank Institute’s flagship course, “Population, Reproductive Health and Health Sector Reform,” trains public and private sector professionals involved in SWAPs. The course content includes “technical and knowledge services related to designing and implementing the new approaches agreed during ICPD” (WBI, Course Brochure, 1999).

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Judging from policy guidelines and rhetoric from donor and government institutions, we might expect to see a strengthening of maternal, prenatal services. On the face of it, SWAPs seem to be conducive to creating a positive environment for strengthening women's reproductive health and rights.

Decentralization and community participation aspects of sector-wide programs represent an opportunity to overcome the lack of sensitivity to women's dignity, needs and preferences and to encourage women to use public health facilities. Experience in Tamil Nadu suggests that this could be achieved by "involving women at the design and planning stage [of construction] to take care of issues of privacy, toilets and other facilities" (Ramachandran, 2000). However, negative examples of decentralization remain forceful reminders of its complexities. Aitken (1998) argues that "the most resistant barriers to the successful implementation of reproductive health programs may be the innate conservatism and resistance to change of health workers themselves. The culture-based reluctance to provide services to teenagers or to women with incomplete abortions is a familiar problem" (p.14). The Women's Health Project (WHP) based in South Africa provides an example of how to improve the responsiveness of a decentralized health system. The WHP is involved with participatory training of health workers to help ease the integration of primary health services (*see Appendix 2*).

Linking the payment of user fees to findings of local monitoring groups is a possible way forward (Ramachandran, 2000). Involving local women's groups in the monitoring and evaluation of quality of care would need to be backed up with sanctions against offenders, without jeopardizing the safety of the women involved. At the very minimum, indicators of dignity should be incorporated in management performance indicators (provision of private toilets, privacy in examination rooms, cleanliness) (Ramachandran, 2000).

Such interventions, however, need to be built into the sector-wide system of accountability to prevent the victimization of local women's groups and stakeholder committees. This raises the important issue of social norms and conventions and the significance of informal rules that influence the way men and women, boys and girls are able to interact with health sector institutions at local levels. Strengthening women's voices at local levels is a complex process, often at odds with traditional conventions (*see One World Action, Report. One World Action Seminar: Developing Gender-Sensitive Local Services, 2001*). This is particularly important in the context of decentralization, where local prejudices and power structures can have a strong influence not only on the supply of



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services, but also on women’s access to and delivery of reproductive health services. They can also influence the degree to which women and women’s organizations can actively influence service delivery and policy priorities at local levels. Thus, the political economy of gender relations and the nature of women’s rights in communities needs to be considered when identifying the best strategies for influencing reproductive health policy, delivery and monitoring at local levels.

### **The Role of the Private Sector: NGOs in Service Delivery**

The shift away from family planning to broad-based reproductive health strategies and services involves changing the “culture” of the health service. In some countries, deeply entrenched practices which disadvantage and disempower women may be very difficult to change. Here, monitoring public services may not be the most appropriate path to take. Instead, exploring opportunities for NGOs to act as alternative suppliers of services may be an alternative, or complementary, approach. In Bangladesh for instance, the most successful initiatives regarding provision of services which support women’s basic reproductive health and rights—women’s need for information and counseling—are to be found among NGOs. The Bangladesh Women’s Health Coalition represents one of many such NGOs.

## **5. Mechanisms to Bring Reproductive Health Concerns into the Debate on Health Sector Reform**

### **Stakeholder Consultation**

Consultations with government bureaucrats, professional providers (doctors and nurses), health-oriented NGOs are, in theory, a part of the sector-wide process and provide an opportunity to influence priorities in the sector strategy. Experience so far suggests that doctors and high-level government officials have the strongest voice in the stakeholder process.

Nevertheless, the stakeholder participation process does offer an opportunity for local NGOs and other advocates of women’s health and rights to influence and shape the components of the service delivery package. This may take place at central government levels, through the lobbying of donors and government officials (as in the case of Bangladesh and India, for example).

Stakeholder participation may be most effective at local levels where local service delivery and political machineries are more responsive to community input. This appears to be the case in Brazil where women’s organizations in São Paulo successfully

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lobbied local government for a Women’s Health Care Office within the Municipal Health Department in charge of managing women’s health care services at municipal health facilities. It’s “main achievement” was to implement the Women’s Comprehensive Health Program (PAISM) with a gender perspective to improve health indicators in the city (Araújo, 2000). They found that introducing a gender perspective into the health sector institutions at all levels challenged the system’s culture and hierarchical structure which treated unequal power relations as “natural” (Araújo, 2000).

### **Linking Local Priorities and Initiatives to the Sector-Wide Approach**

To protect and strengthen reproductive health and women’s rights in the context of SWAPs, the best methods to link local priorities and initiatives to the sector-wide approach will depend to a large extent on country circumstances. There is a clear need, therefore, to think about the best ways to link local strategies to sector-wide processes which are controlled from the center by ministry officials and donor partners, albeit with varying degrees of input from various stakeholders (professional bodies or NGOs, for example). Indeed, local responses to sector-wide reforms will determine their ultimate impact. Women’s perceptions, needs and priorities (among providers and potential users) need to be fed into the policy process at both central and decentralized levels.

“The reproductive health community, particularly health and rights advocates, have to become fluent in health sector reform issues and must be particularly vigilant in ensuring that reproductive health concerns are addressed, especially in international and country-level discussions about financing, priority-setting and resource allocation” (Jodi Jacobson, cited in CHANGE and Population Council, 1998).

The evidence so far suggests that initiatives need to take place at local, national, regional and global levels.

### **Integrating a Gender Perspective into Sector-Wide Management and Global Initiatives**

Even in an environment where many responsibilities are being devolved to decentralized districts, overall strategies and total funding allocations are usually determined at central level, with varying degrees of input from stakeholders located in health facilities and communities. The overall sector framework, which sets out mechanisms of accountability, identification of priorities and allocation of funding is for the most part determined at central levels. The monitoring and evaluation of the effectiveness,

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equity and efficiency of sector programs is also concentrated at central levels—within the Ministry of Health and among the SWAP donor consortium.

“Now, policy analysis, technical support and national planning are becoming the dominant responsibilities of the center, and we need to recognize and address that shift in roles” (Iain Aitken, cited in CHANGE and Population Council, 1998).

In this context, mechanisms are needed to channel local monitoring and evaluation efforts back to the center. At the same time, mechanisms are needed to shift the systems of accountability (financial reporting, public expenditure review, annual program review, etc.) away from the center to local levels. This can best be achieved by ensuring that a gender perspective is adopted in the management of sector-wide process and that explicit attention is given to the central importance of ensuring women’s reproductive health and rights. We refer to this as an essential aspect of “mainstreaming” gender into sector-wide programs.

Initiatives by the Commonwealth Secretariat (UK) in partnership with the United Nations offer a potential resource to support strategies to strengthen women’s health and reproductive rights objectives in the management of sector-wide programs. A network of UN organizations is a project of the UN Inter-Agency Committee on Women and Gender Equality includes, among others, WHO, UNIFEM and PAHO. Publications of this network are centralized on a website and offer useful and relevant on-line resources which include *Gender Mainstreaming: Management* (ComSec) and *Operationalizing Cairo and Beijing: Training in ‘Gender and Reproductive Health* (WHO, forthcoming). A full list of resources can be found on their website, <http://www.col.org/GenderResources>.

As yet, however, there is no evidence of gender analysis being integrated into sector-wide management, and perhaps this objective is best addressed as a long-term strategy.

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## Part II

# The Reproductive Health Agenda in the Context of Health Sector Reform

### Introduction

This section will illustrate how sexual and reproductive health is being interpreted and implemented in the context of health sector reform programs. Bearing in mind the preceding analysis of health sector reform in the context of globalization, the following analysis aims to identify opportunities, strengths and weaknesses of health sector reform/sector programs regarding sexual and reproductive health. The significance of reproductive health initiatives within the context of reform is particularly relevant since many of the countries that agreed at Cairo to implement reproductive health initiatives are also now undertaking health sector reform.

Bringing sexual and reproductive health services to the millions of people living in countries which still suffer from short life expectancies, high levels of child and maternal mortality, child labor, illiteracy and poor overall health remains a major challenge for governments and donor organizations. It is estimated that 80 percent of the world's population now lives in developing countries, as do 90 percent of the world's young people. The total world population will rise from six to nine billion people in the next 50 years.

Despite progress in the field of sexual and reproductive health, the world's population grew massively from 3 billion in 1960 to 6 billion in 2001. The world's 13.2 millions AIDS orphans and the persisting high rates of abortion and maternal mortality in low- and middle-income countries reflect the need to scale up efforts to change the way sexual and reproductive health services are delivered. Despite policy commitments towards sexual and reproductive health, development agencies are still struggling to turn rhetorical commitments to gender equity and equality into concrete sector program initiatives and to integrate gender concerns into health reform programs. This situation highlights the need to generate the political will to make progress in sexual and reproductive health within the context of health sector reform (HSR). As the analysis of HSR and globalization demonstrated, sector reforms are complex, and their success requires political commitment, time, resources and a favorable policy environment.

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## 1. Why Should HSR be a Priority Issue for Reproductive Health Advocates?

Some of the resources used in the preparation of this section are internal government reports. Since they are not published documents, they can not be quoted, particularly regarding specific numbers in specific countries. The references cited only include documents made publicly available.

In the 1990s, the global UN conferences agreed to a series of international development targets for 2015 which included appropriate access to reproductive health services and a 75 percent reduction in maternal mortality rates.

The International Conference on Population and Development (ICPD, Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) established a more comprehensive and holistic approach to general health care and especially with regard to sexual and reproductive health. The principles of equity, quality and accountability embodied in the programs of action from these conferences required moving beyond the scope of isolated projects to address both national health systems as well as other sectors having a direct or indirect impact on health.

Since reproductive health and HSR both share the goals of equity and equality, the agreement among bilateral/multilateral donors and development partners to advance beyond the funding of individual projects to coordinate actions towards a sector-wide program seems a good opportunity for advancing the sexual and reproductive health agenda. However, sexual and reproductive health goals and principles of equality and equity, quality of services and user empowerment may be incompatible with prevailing institutional cultures within the health system. Health sector reforms tend to be consistent with society's gender-biased views and values.

Sexual and reproductive health is now understood as a multi-sectoral concern. The need to incorporate an approach that tackles the economic, structural and systemic issues linked to the health system—including the need for an effective and accountable health sector—is now acknowledged in health policy. Multi-lateral agencies must act together to support countries in their efforts to reform their health sector policy and institutions, and at the same time, civil society must hold all sectors responsible for protecting and promoting sexual and reproductive health.

This new understanding directly addresses concerns about “one-size-fits-all” approaches to structural adjustments in developing countries. There is no blueprint for health reforms; rather, they are country-specific (Enemark and Schleimann, 1999). Analyses



*Development agencies are still struggling to turn rhetorical commitments to gender equity and equality into concrete sector program initiatives and to integrate gender concerns into health reform programs.*

comparing the different countries where HSR is being implemented reveal that health policies and strategies vary considerably (DGIS, 1999). The reasons and timing of launching sector reform—as well as procedures and mechanisms for policy development, planning and implementation of health programs—also vary from country to country.

Common health problems and challenges in low- and middle-income countries may demand similar health strategies and interventions, but the specific characteristics and dynamics of a country's health system are likely to generate differences in the implementation of the reforms. In any case, if health reforms are to succeed, they require the leadership and participation of both the national governments and the wider civil society in the development of broad health policy framework and specific reform plans. Stakeholder participation is now widely recognized as a critical condition for success.

A crucial aspect of HSR is capacity building in poorly-equipped Ministries of Health so that governments will have an effective budgetary and institutional framework. Governments' financing mechanisms must be developed in order to make changes sustainable when external sources of funding are no longer available.

HSR programs and objectives tend to be quite ambitious. Increased coverage at the level of basic health services serves a political purpose but rarely is matched with realistic considerations of the financial and human resources needed to provide such services. In theory, the integration of vertical programs should improve efficiency: however, integrating efficient vertical programs into inefficient general services may jeopardize the quality of some of the newly-integrated services.

Despite considerable rhetoric, there has been relatively little investment by governments and international institutions in primary and preventive sexual and reproductive health interventions other than contraceptive delivery (Population Council, 1998). In a context of extremely under-funded health systems in which a more functional service delivery is very difficult to attain, family planning resources tend to be greater than maternal and child health (MCH) resources, yet the burden of care has been on the MCH workers.

All sector reform programs acknowledge sexual and reproductive health as a priority policy. However, when institutional changes or budgetary allocations are made, sexual and reproductive health and gender issues are set aside in favor of other, competing priorities resulting from an overburdened health system, pressure from



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powerful special interest groups, and the acute health needs of a large, impoverished population. As a result, inequalities between women and men that are primarily caused by structural and institutional discrimination remain either openly manifest or latent within the health sector and its program interventions.

HSR is not a uniform concept. It covers a wide range of structural and institutional changes which have definite consequences for gender equity, sexual and reproductive health, and the general health of the entire population. When some of the dilemmas that have direct or indirect impact on sexual and reproductive health are highlighted, the enormous implications of the HSR approach for sexual and reproductive health advocates, and thus for institutions such as the Ford Foundation, become clear. Identifying the barriers and opportunities for bringing a gender perspective to sexual and reproductive health in a context of HSR will enable the RHAG to create options to drive the HSR and sexual and reproductive health agenda forward.

Sexual and reproductive health advocates can have a significant influence on the reform process once they understand their possible role in managing change within the health sector. Achieving this understanding sometimes requires re-training of staff and possibly changes in the skills mix, attitudes and organizational structure of the advocates' institutions.

Being part of the HSR process requires an understanding of the reform's main components and of the development of the reform process within a country. Only then will it be possible to influence the HSR process to ensure that it supports reproductive health objectives and is gender-sensitive.



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*If health reforms are to succeed, they require the leadership and participation of both the national governments and the wider civil society.*

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## 2. Can HSR Provide Accessible, Equitable, Gender-Sensitive and Good Quality Health Services?

HSR seeks to address crucial deficiencies that affect how well the entire health system functions. Sexual and reproductive health services are part of this system and share with other health programs similar problems of poor quality of care, insufficient funding, limited access to services and inefficiencies in service delivery, as well as lack of accountability and failure to incorporate users' perspectives.

Health reforms are also a response to a number of resource constraints in the health sector. We all know how carefully available health sector funds—including those earmarked for reproductive health—have to be administered to get the optimal benefit for the vast majority, particularly the poorest segments of the population. However, reform implies change, and this is not always welcomed with open arms. Many interests are likely to be affected, and different stakeholders may have different views regarding HSR goals and priorities.

Even the language of HSR as expressed by international agencies and governments has changed over the decade from the early 1990s. The “first generation” of reforms was supply-side driven and focused on the health sector (Standing, 2000). One of the top objectives was to reform the operations of Ministries of Health, specifically their technical and managerial activities. Gender was not addressed as a concern in the planning or implementing of these health reforms. Monitoring systems to show the impact on service delivery and outcomes for health were not developed. This first generation assigned priority to the following elements:

- improving health sector management systems;
- public sector reform;
- reform of financing mechanisms, cost containment;
- decentralization; and
- working with the private sector.

The “second generation” conserved these five elements, and added a broader perspective, emphasizing demand side, anti-poverty interventions and intersectoral approaches to health. The following elements were added:

- partnership with key stakeholders;
- focus on community/user needs; and
- health as part of the poverty agenda.

The international agenda also has broadened its understanding of poverty and its causes, focusing on intersections between poverty

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and health. Health financing strategies now consider risk, vulnerability and exclusion to develop safety-net mechanisms to protect the poorer segments of the population. Gender implications are yet to be explored.

These new components have presented an opportunity for a variety of civil society groups, such as NGOs and other independent organizations, to develop advocacy strategies and to participate actively in planning, service delivery and/or monitoring. However, many stakeholders are not yet involved in discussions about health sector reform or sector-wide approaches. Realizing the participation and active involvement of multiple partners who have different mandates, organizational foci, work styles and budgets requires a thorough stakeholder analysis (DGIS, 1999).

At the district level, operations are more flexible to tailoring of sexual and reproductive health services to suit local needs. While decentralization opens possibilities for further development of the district health system, it also poses new challenges, particularly to primary stakeholders. Aitken (1998) questions the impacts of decentralization on sexual and reproductive health when government commitments to the 1994 Cairo Agenda are not implemented at the local level, either because resources are not budgeted or because of conflicting interests and views between the center and the periphery.

For instance, hiring and firing of staff, procurement and disbursement of funds, and acceptance of donations are all heavily centralized in the capital cities and subject to slow and complicated procedures. Difficulties also arise in the selection of local representatives and delegation of authority to them. Political tradition and motives may hamper the delegation of power, and as a result, most essential decision-making and executive authority continues to be retained by the central government.

Paradoxically, as more power is conferred upon local representatives, the power is brought closer to the people, and thus the power and the nature of the administration actually is legitimized. However, conferring power on incompetent local representatives can also have the undesired effect of deepening existing gender and health inequities. In addition, local will can be influenced by conservatism and prejudice, particularly in the case of services such as management of incomplete abortions or sexual health services for adolescents.

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Some of the greatest obstacles to successful health sector reform are Ministry of Health rules and regulations which are usually out of synch with the new type of HSR mandates. These explicit and implicit guidelines have been accumulated over decades of bureaucratic activity and usually are written and endorsed by civil servants and politicians who find it difficult to make the changes expected in sector reforms. These regulations prevent rapid and flexible response and seriously undermine the Ministry's ability to carry out operational public administration of HSR.

### **Relevant Questions for Analyzing the State of Sexual and Reproductive Health in Current HSR Programs:**

- Which of the four broad stages of HSR is the country developing: consideration of HSR; HSR planning; implementation of HSR; or post HSR?
- Who is leading the HSR process: donors, government (which ministry)? Which stakeholders are part of the HSR process?
- How can the HSR process be influenced? Through governments, donors, NGOs, other actors?
- Which concerns and approaches are shared by most institutions involved with sexual and reproductive health?
- Which indicators will be used to measure the reform's success? Are indicators for sexual and reproductive health included?
- How long can each actor commit to the HSR process?
- In what way can each actor commit to the HSR process (representation, finance, network, information, expertise)?
- Why are the various stakeholders interested in engaging in the HSR process?
- How can sexual and reproductive health be made a priority within HSR? How can the reproductive health agenda be encouraged at municipal, national and donor levels in a HSR context? How can it be ensured that political commitments to sexual and reproductive health are endorsed and backed up with the necessary human and material resources?
- How can it be ensured that the sector-wide approach will go beyond HSR and have the implications analyzed in the preceding section on globalization?

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### 3. How Can HSR Be Used to Improve Sexual and Reproductive Health?

The paradigm shift in Cairo made sexual and reproductive health a comprehensive concept with a user-friendly and gender approach to service delivery, thus providing a good test of health reform outcomes and outputs. However, women's health advocacy groups which have successfully created international political spaces to advance progressive sexual and reproductive health policies have not been able to engage in similar dialogues with the national and international agencies driving HSR.

At the service delivery level, a very valuable experience has been gained with the approach to sexual and reproductive health, but it has not been easy to scale up this experience to the health system level. The success of micro-level initiatives (*see Appendix 4*) seems condemned to limited demonstrations when it comes to increasing their proportion in the context of a malfunctioning system.

The bias towards public services makes it difficult to involve other non-profit, private health-care providers—such as NGOs and mission hospitals—in policy dialogues and sector reviews. The HSR programs neither include mechanisms for a rational public-private mix, nor do they adequately address relevant areas for sexual and reproductive health, such as nutrition and HIV/AIDS. Nor do they deal with concerns of water and sanitation, since intersectoral activities are not considered part of HSR programs.

These biases—in addition to the problems mentioned in part four of the globalization analysis—have jeopardized the sexual and reproductive health agenda. Among other reasons for limited progress in realizing ICPD objectives, Standing mentions the following:

- Reproductive health has been framed within a different language from HSR (i.e., human rights/women's empowerment concerns v. managerial/technical concerns).
- Similarly, reproductive health has been focused on service delivery issues, to the neglect of broader, systems-level thinking. Systems issues are quite hard to address. One problem is the institutional placement of reproductive health. Because it is largely based in vertical programs (e.g., family planning, MCH), the various components of reproductive health are often split between different ministries/sectors, producing stakeholder conflicts between different ministries. Reproductive health tends to be a visionary approach, not a technical area with an attached budget.
- A system-wide approach to reproductive health needs to take a broader view of the concept of a system than that common in much of the current HSR thinking. The dominant focus on the

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role of the public sector in health reforms neglects provider pluralism: the private sector plays a very significant role in reproductive health service delivery, often in areas where women find it most difficult to access services, such as abortion provision.

- Progress continues to be restricted by problems of data availability. Little data on reproductive health is available disaggregated by age, location (urban-rural), class/income, religion/culture and ethnicity. Country studies of program implementation suggest little serious attention by policymakers. There are currently no agreed core indicators for monitoring a rights-based approach to women's health as advocated by the Beijing Platform for Action.

Because of these shortcomings, the following questions regarding sexual and reproductive health seem pertinent.

### **Key Questions Regarding Sexual and Reproductive Health in HSR**

- Are sexual and reproductive health rights being considered sufficiently?
- Are all the important national and international partners who provide financial and technical support for the advancement of the sexual and reproductive health agenda involved in the reform process?
- What institutional vehicles exist—at various levels—to coordinate efforts on and discussion of the different agendas of the various stakeholders concerned with sexual and reproductive health?
- Should parallel funding of sexual and reproductive health programs be continued? What would be the consequence for HSR programs?
- What kind of mechanisms can be developed to monitor and influence non-government expenditure in sexual and reproductive health?
- If clear mechanisms for a public-private mix are lacking, can donor agencies continue to provide parallel support for private, non-profit institutions with a public purpose (national NGOs, mission hospitals)?
- What are the consequences for sexual and reproductive health if the HSR monitoring framework does not include financial indicators to differentiate spending on specific health programs and services?
- What is the relationship between HSR and sexual and reproductive health strategies and outcomes from a gender perspective?



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*The success of [sexual and reproductive health] micro-level initiatives seems condemned to limited demonstrations when it comes to increasing their proportion in the context of a malfunctioning health system.*

Gender relationships within health system bureaucracies and their program activities tend to reflect and reinforce rules, traditions and social relations existing in the organizations and the wider culture which together determine how power is allocated and used differently by men and women in making decisions on issues that affect their health. At present, gender equity concerns have been incorporated unevenly in HSR at the policy level, and efforts to decrease gender disparities in health care and health lack monitoring instruments to show the relationship between inputs and outputs. At the institutional level, for instance, during the redefinition of basic health services or in the design and implementation of human resources development policies, the intervention of bureaucracies often actively produces or reinforces gender differences and impacts.

Gender inequities and inequalities exist both in consumption and provision of health services. Ideally, HSR should incorporate principles of gender equity and acknowledge gender mainstreaming as one of the primary objectives of the reform. Unfortunately, HSR usually fails to address gender concerns, which can have an adverse impact on women's health, especially on their reproductive health.

Ministry of Health rules and regulations are highly complicated, gender-blind, and require an extensive and expensive bureaucracy. At the local level, committed administrators and motivated staff with proper experience, knowledge and skills are in short supply. As a result, community health services will reflect the gender bias and the bureaucratic approach embedded throughout the Ministry's institutional culture. Lack of gender-sensitive personnel (who actually understand how to make the health system work), in combination with lack of accountability and law enforcement, act as major barriers to the access of poor men and women to all levels of health services.

A gender perspective goes beyond sexual and reproductive health. It should permeate all policies, plans, program designs and implementations of HSR. Local gender analyses are available for most countries implementing health reforms, but they rarely feed into policies and plans generated during HSR.

In some cases, where HSR gives consideration to some gender differences—in reproductive roles, access to and control of resources and decision-making, during policy formulation and program design—gender mainstreaming remains extremely difficult in practice. An example can be found in the Bangladesh analysis in *The Gender and Reproductive Health Impacts of Health Sector Reform in Asia*, the proceedings from the regional meeting in Lijiang, Yunnan Province, China, March 12-17, 2000.

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Decentralization and financing systems are two examples that illustrate the relationship between gender and health equity. The many successful experiences at micro level involving multisectoral approaches to sexual and reproductive health rarely achieve larger scale due to the complexity of national structures, such as the Ministry of Health. Local government units may be more propitious for the implementation of integrated development approaches aiming for gender and health equity. However, political and bureaucratic dynamics between center and periphery create complex conditions for gender equality (Aitken, 1998).

Financing systems implemented by health reform programs have a clear impact on sexual and reproductive health. The gender implications of cost recovery have been documented and reveal how service charges can result in a decline in the use of maternity services, particularly at the hospital level (Kutzin, 1995). Other studies (Schneider and Gilson, 1999) show that government removal of user charges for MCH services may not necessarily result in any increase in the use of maternity services. This suggests that aspects of quality of care—such as better treatment at facilities—are very much valued.

Another area of concern regarding gender and health equity are the different modalities for funding individual/household health-care needs:

- insurance schemes for formal sector workers;
- basic health insurance or community financing for the moderately poor; and
- micro-credit and funds for catastrophic illness for the very poor.

Existing literature reports that there are sensitive areas for women which put them at a disadvantage. Among the most notorious are the additional payment burdens or other penalties on women to cover maternity care in health insurance schemes (Standing, 2000). Coverage in basic health insurance schemes is selective and does not necessarily include sexual and reproductive health conditions. Micro-credit and funds for catastrophic illness for the very poor tends to be small-scale and run by NGOs. Although these should be multi-sectoral initiatives, they receive no support from the health or other sectors. A report from India (Ramachandran, 2000) shows a correlation between poor women taking loans to cover costs of hospitalization and an unusually high rate of referral for hysterectomies in private-sector facilities. This is just one illustration of how distorted official structures and health providers can destroy NGOs efforts.





*Gender inequities and inequalities exist both in consumption and provision of health services. Ideally, HSR should incorporate principles of gender equity and acknowledge gender mainstreaming as one of the primary objectives of the reform.*

Finally, HSR has focused on public health services alone, failing to incorporate the diversity of healing practices and health-care alternatives that are of particular relevance to the poorer segments of the population. In this regard, a variety of gender issues can be identified in the way male and female users respond to the unregulated market. When dealing with sexual and reproductive health problems, poor and low-income women in particular seem to be very sensitive to what they perceive as quality of service (attitude of the provider, waiting time, etc.). Ways of monitoring and regulating the wide diversity of health providers and practitioners need to be developed as well as ways in which the benefits of alternative healing practices can contribute to improve the health status of the population.

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## Part III

# Action Points for the Ford Foundation, Partners and Others

One of the strengths of the Ford Foundation's Reproductive Health Affinity Group (RHAG) and its partners is at the community level, as is evident in the Foundation's actions in health sector reform in Asia. We take this as the starting point and prime focus when considering ways to strengthen activities supporting women's health and reproductive rights in the context of health sector reform and globalization. Building an effective base of information and advocacy from the community level seems to be one of the most appropriate strategies for grantmakers funding at the grassroots level.

Mechanisms to bring reproductive health concerns into the debate on SWAPs tend to be located at centralized levels of policy formulation and within the key international and national institutions. Therefore, an appropriate approach for grantmakers may be to strengthen the stakeholder components of health sector reforms and, within this process, support women's voices. Such work is already underway by Ford Foundation partners in Latin America (*see Appendix 3*).

Another general point which we see as critical to supporting women's reproductive health and rights is widening the scope of the debate on globalization, health sector reform and gender to include other fields, among them: economic development; financial systems; community development; and labor and employment.

### **Considerations for Foundation Partners and Other Actors**

#### **Interactions with Local Government Service Providers**

- Explore possibilities for strengthening the benefits to women users of decentralized (and integrated) health, water and sanitation services. This might include suggestions for improving service delivery and quality of care through community inputs on training or management accountability systems (e.g., community-defined indicators of good performance).



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*An appropriate approach for grantmakers may be to strengthen the stakeholder components of health sector reforms and, within this process, support women's voices.*

- Consider potential for improving dialogue among women's health organizations, local government bureaucrats and local providers.
- Consider possibilities for strengthening women's health and reproductive rights through forging alliances among women health service providers, health workers and service users.

### **Community Advocacy**

- Strengthen women's advocacy at community levels through improving the provision of information to women on how changes in the health sector are likely to affect services that are important to them.
- Explore community-level linkages among women's health, gender and poverty alleviation budget initiatives, for example, in South Africa, India and Bangladesh.
- Identify possibilities for linking community-based advocacy for public sector accountability to specific health demands of women.

### **Improve Community-Based Information and Analysis**

As yet, there is very little information on the impact of health sector reforms, particularly from the perspective of women's reproductive health and rights. In view of their complexity and variation across countries and regions, it would be useful to:

- Look separately at the impact of different aspects of reforms (depending on their significance to women in different communities): for example, user charges; decentralization; privatization of services; integration of service delivery; public-private partnerships, etc.
- Consider supporting coordinated, action-based research activities on the nature of and impact of health sector reforms. This could be done across regions on a pilot basis and, though they would ideally be comparable, would reflect the needs and priorities of the women in communities where the research is being undertaken.
- Use community-based research and information sources to clarify the key priorities and constraints women face in maintaining and strengthening their reproductive health and rights. Link to community-based advocacy.

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## **Developing Alternative Approaches**

- Explore possibilities for improving the positive aspects of decentralization and stakeholder participation in health sector programs.
- Consider the lessons from training and advocacy initiatives in other reproductive health projects internationally.
- Explore possibilities for extra resources to build on and coordinate the community-based findings (such as the Ford Foundation's work in China, for example).

## **Integrate Gender Concerns into Related Areas and Disciplines**

- Improve grantmakers' capacity and accountability to understand and support gender equality and the strengthening of women's rights. Women's rights and gender equality need to be reflected in the mainstream of development and advocacy work.
- Identify possibilities for explicitly integrating reproductive health and women's rights priorities into academic work in the areas of: globalization; international trade; the role of the state (including fiscal policy, government budgets, public-private partnerships); and gender and development.

The authors hope that this report adequately represents the feedback and dialogue with Ford Foundation RHAG members and ourselves. We are grateful for the input they have provided. However, the articulation of priorities for RHAG is rather more difficult than discussing the key issues. We, therefore, raise these issues in this spirit and hope that the text itself (as well as its gaps) will provide RHAG, Ford Foundation partners and others with ideas for future activities.

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# Understanding the Links: Globalization, Health Sector Reform, Gender and Reproductive Health

by **Barbara Evers and Mercedes Juárez**

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# Globalization, Health Sector Reform, Gender and Reproductive Health: The Economic Justice Implications

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## Summary

Evers and Juárez provide a useful and informative review of the “state of the art” in a domain that is still encumbered by conceptual confusion and contradictory trends in public policy and funding, both at the national and the global levels. Overall, “Understanding the Links: Globalization, Health Sector Reform, Gender and Reproductive Health”:

- synthesizes clearly several recent and excellent studies of the gender implications of health sector reform (HSR) (e.g., Standing, 2000; Kunming Medical College/Ford Foundation, 2000; and Elson and Evers, 1998);
- contextualizes HSR within the larger frame of globalization and its impacts on the conditions of women’s employment and reproductive (unpaid household) labor; and
- presents subtle and balanced arguments about the potential effects of such trends as user fees, decentralization of health systems and decline in—or reallocation of—national health budgets on women’s reproductive and sexual health.

These are worthwhile contributions to a subject that is vastly under-researched. Nonetheless, the paper suffers from several weaknesses that bear on economic justice questions and that I shall address in greater detail below. Let me first summarize my main points:

The paper tends to treat HSR as though it were identical to sector-wide approaches (SWAPs), and SWAPs as though they were an omnipresent reality rather than a formula developed by international health economists, a formula which so far has had very little real impact nationally or locally in most countries. In part, this is

due to the absence of systematic, cross-country, comparative data (a point the authors make forcefully on pp.38-39). Yet anecdotal evidence available at this time suggests a disparity in HSR between theory and practice, which raises the question of whether not only its practical implementation but its very meaning might vary greatly from one country to another. Behind this conceptual confusion, what passes for “reform” in many countries may have little or nothing to do with economic justice or human rights.

Second, the authors approach the entire subject of HSR from an internal rather than a critical perspective. This means that, instead of questioning its underlying assumptions and economic biases or how these may conflict with other approaches (for example, those based on human rights or sustainable human development), they accept the claim by HSR advocates that their goals are “equality” and “equity” without offering any evidence to this effect. I shall argue that the differences go deeper than language or, rather, that language matters; it *signifies*. When we call the women who rely on reproductive health services “consumers,” we reinforce the marketization of health care rather than contest it.

On a related third point, while Evers and Juárez several times comment on the tensions between sector-wide and multi-sectoral approaches, they fail to integrate that insight fully into their analysis or to examine in any depth its discouraging implications for realizing the sexual and reproductive rights vision of Cairo and Beijing. Both the matter of equal access to quality health services and the establishment of integrated and cross-sectoral systems of service delivery directly raise important issues of *resources* and how they might be distributed more justly within and across countries and regions—an issue that Evers and Juárez largely evade.

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Finally, I very much agree with the paper’s emphasis on “community-based initiatives” and developing a process for involving women’s groups as “stakeholders” in HSR at all levels. However, I wish the authors had paid more attention to the most vexing problems concerning the form such involvement should take—including the ambiguous situation of NGOs as alternative health providers and the ambiguous relationship of women’s health NGOs to popular social movements. These issues of *accountability* are inseparable from approaches that stress both economic justice and human rights.

### On Economic Justice

Economic justice concerns normative principles for the fair distribution of the social and material necessities of life among individuals, communities, countries and regions of the globe, without discrimination based on gender, race, ethnicity, nationality, religion, sexual orientation, occupation, marital status, immigration status, etc. In other words, economic justice has both “macro” and “micro” dimensions and, as I have argued elsewhere, cannot be separated from human rights. This is so because (a) economic and social rights are an essential part of the human rights armament within international treaty and customary law, and (b) individual rights—of free expression, “choice,” self-determination, bodily integrity—are meaningless without the necessary social and economic conditions that make their exercise possible. I cannot “decide freely and responsibly the number, spacing and timing of [my] children” if I have no income or insurance to pay for the services, no means of transport to reach the clinic, and no child care or time off from work to accommodate the long wait once I get there (see Petchesky, 2000a; Petchesky, 2000b; and Corrêa and Petchesky, 1994).

Sexual and reproductive health—understood as human rights in themselves (ICPD Programme, Art. 7.3; Beijing Platform, Para. 96) and as part of the basic “right to the enjoyment of the highest attainable standard of physical and mental health” embodied in the WHO Charter and the UN Convention on Economic,

Social and Cultural Rights—have obvious links to economic justice. Without access to the necessary material means, individuals cannot achieve reproductive and sexual health for themselves and their children. And without access to the necessary resources and infrastructure, societies cannot make adequate sexual and reproductive health care, or health care generally, available to their citizens and residents. Because these various rights and needs are so densely interwoven in people’s lives, systemic and budgetary approaches that treat health in isolation are ultimately unsatisfactory.

Sometimes the right to health care, including reproductive and sexual health care, is pitted against other rights, particularly those associated with property ownership. For example, this has occurred in recent conflicts between transnational pharmaceutical companies that insist on the inviolability of their intellectual property rights and patents under rules of the WTO and certain governments (South Africa, Brazil), supported by civil society groups representing people with AIDS, who assert the right to affordable, life-prolonging medicines as part of the human right to health care. It can easily be argued, however, that within the framework of international human rights norms, corporate property interests cannot trump principles of economic justice, even under conditions of globalization and deregulated markets. In accordance with this view, Art. 80 of the WSSD+5 “Further Initiatives” document, adopted by consensus by 186 countries in June 2000, puts “the right of everyone to the enjoyment of the highest attainable standards of physical and mental health” as well as “the critical importance of access to essential medicines at affordable prices” *above* intellectual property rights. It further maintains that the latter should be exercised “in a manner conducive to social and economic welfare.”<sup>11</sup>

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## **Absence of Cross-Country Data, Comparability and Conceptual Coherence in “HSR”**

Evers and Juárez present a very concise, systematic and somewhat formulaic synopsis of the elements of HSR (Section 2a and b), and at the same time, refer frequently to the absence of multi-country studies or concrete data showing “the linkages among globalization, health sector reform and women’s health and reproductive rights” (p.12). Studies being undertaken by CHANGE in Washington and the Women’s Health Project in South Africa may begin to fill in important gaps in our knowledge about these linkages. But it seems to me that a more serious problem in drawing useful comparisons from cross-country analyses is the huge variations in what is being “reformed” in different countries or in fact whether a given country even has a health system in place to be reformed.

By way of example, some well-developed public health systems in Asia with strong emphasis on primary health care (PHC) are being eroded rapidly through privatization (China and Malaysia); other countries never had any public health system at all (India and Philippines). An innovative cross-sectoral approach may have beneficial implications for reproductive health in one country (Pakistan), while a narrow, vertical approach to reforming family planning is favored in another (India) (pp.24 and 22; also, Kunming Medical College/Ford Foundation, 2000; and Simon-Kumar, 2000). Most common, perhaps, is the post-Cairo pattern in which “efficient vertical programs” are meant to be integrated with “inefficient general [MCH or PHC] services” (p.39), resulting in a weakened system overall.

This suggests that if we distinguish HSR as an academic model from existing reforms or structural transformations of health policies and programs on the ground, then “HSR” as a single unifying rubric begins to lose any conceptual coherence. We might be better off conducting specific investigations (comparative, across countries) of targeted aspects of recent trends and how they impact on sexual and reproductive health—for example, national financing

schemes, user fees, integrated versus vertical structures, decentralization, essential packages of services (EPS), etc.—and recognizing that the present “mix” of these elements in a given context may not represent “reform” at all in the sense of deliberate policies aimed at improving access and quality in health care for the vast majority.

The paper’s discussion of financing mechanisms (pp.27-30) underscores the desperate need for more data within countries, across countries and across regions. In addition, the “conclusions” in this section raise more questions than they answer. For example, how do public insurance programs—not really mentioned in the paper—compare with private insurance in terms of both constituencies served (by class and income as well as gender) and coverage of specific sexual and reproductive health services—e.g., contraception, maternity costs, infertility treatment, prevention of STDs and gynecological cancers, etc.?

Likewise, the paper makes an excellent point with regard to possible trade-offs between user fees and informal costs associated with formerly “free” services (p.29). However, we still need comparative data analyzing user fees in specific country and local contexts; comparing the costs (informal as well as formal) to women and the poor of public, private non-profit, for-profit, NGO and other types of provider; and broken down by rural/urban location, class, ethnicity and gender.

## **Factoring in Gender**

The paper is very well grounded in an analysis of the ways in which globalization exacerbates conditions of gender inequality prevailing in most countries and especially with regard to deteriorating conditions of employment for women in developing countries. A surprising gap, however, is the lack of attention to women migrants and refugees in both developed and developing country contexts, given the enormous impact of globalization (or its uneven spread) in creating growing populations of internal and transnational migrant workers, many of whom are women and girls. The inclusion or exclusion of migrant and



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refugee populations from social security, health and other benefit programs based on national protection systems is surely an economic justice as well as a human rights issue. Insofar as HSR projects contain not only a “bias towards public services” (p.44) but also a bias towards citizen-based rights to those services, such projects will not address the sexual and reproductive health needs of migrant and refugee women and girls. This problem highlights the necessity—from an economic justice and human rights standpoint—of viewing gender oppression as it *intersects* with other forms of discrimination such as those based on race, ethnicity, class or immigrant status, rather than in isolation (see NGO statements at [www.whrnet.org/wcar/wcar.htm](http://www.whrnet.org/wcar/wcar.htm) and Beijing Platform for Action, Para. 46).

In considering the forms of empowerment that might enable women to realize their reproductive and sexual rights and to make their own decisions, the paper is useful in pointing out that women’s access to employment and income by itself may involve trade-offs: greater decision-making autonomy in return for less time, more strains on health, and greater responsibility for family expenses (p.14). Yet the discussion of gender inequalities in specific relation to sexual and reproductive health and rights seems limited; it fails to take into account the ways in which deeply-embedded cultural norms—diffused through religious institutions and the media among others—may undercut women’s and girls’ access to vital services even when they have the economic resources to purchase them. This is obviously the case with respect to safe abortion and contraceptive and STD prevention services for unmarried adolescents in many countries.

One significant cross-cultural finding of the International Reproductive Rights Research Action Group (IRRRAG) in its seven-country study was that women’s sense of entitlement to make decisions and claim public services often correlated to their involvement in community-based organizations (Petchesky and Judd, 1998), perhaps even more than their access to independent earnings or education. This tells

us that economic rights cannot stand alone but must be integrated with political, social and cultural rights, including the conditions for a strong civil society. But the narrowly economic focus of HSR projects makes it unlikely they will encompass these aspects of women’s empowerment.

Economic justice entails not only access to quality services, but also protections and job security for the low-level health sector workers who are disproportionately female. Evers and Juárez are attentive to the ways that HSR may have negative effects on women not only as “consumers” but also as providers of reproductive and sexual health services (pp.21 and 26). However, we need much more in the way of concrete, context-specific data on, for example, how the integration of services or cost-recovery mechanisms may be placing disproportionate burdens on nurse-midwives, maternal and child health workers, or women as unpaid family and neighborhood caretakers; or may be displacing public sector health workers; or, on the contrary, may be having no influence on women’s preference in some settings for traditional healers over formal sector providers, public or private, and why this is so.

### **The Hidden Assumptions of HSR: Privatization, Commodification and Cost-Effectiveness**

On page 31 of their paper, Evers and Juárez conclude, somewhat tentatively, that “on the face of it, SWAPs seem to be conducive to creating a positive environment for strengthening women’s reproductive health and rights.” But even the limited evidence they are able to muster provides little basis for such optimism; more reflective interrogation of the dominant discourse and conceptual framework that surround HSR models raises serious questions about the extent to which their goals and priorities are compatible with the rights-based approach and emphasis on gender equality contained in the Cairo and Beijing documents.

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Evers and Juárez do address this problem explicitly (pp.37-40), acknowledging the “managerial/technical concerns” that are overriding for HSR advocates, as opposed to the “visionary approach” of sexual and reproductive health (p.44). But, rather than stepping outside the HSR framework and viewing it critically, their emphasis seems to take the HSR parameters as givens and stir in gender and reproductive health, or adapt sexual and reproductive health to the HSR parameters (e.g., figuring out how to consolidate sexual and reproductive health into a single, integrated budget).

If we approached the matter from an economic justice and human rights perspective, however, we would need to raise fundamental questions on at least two levels: first, the assumptions embedded in the language of cost-effectiveness and “consumer demand”; and second, the limitations of sector-based reforms, not only for sexual and reproductive health but for health in general.

In a publication commissioned by the UN Research Institute for Social Development last year, I wrote: “In theory, there is no reason why the criteria of efficiency and cost-effectiveness should be incompatible with either better health outcomes or the goals of equity and human rights; indeed, inefficient and wasteful health systems can hardly be socially just. Moreover, some HSR advocates surely have distributive justice in mind—for example, challenging governments to finance primary health care rather than tertiary care hospitals” (Petchesky, 2000c). This also seems to be the “benefit of the doubt” attitude of Evers and Juárez, all of us having been influenced by Tom Merrick, who administers the World Bank’s course on HSR.

However, the fact that cost-effectiveness is logically compatible with human rights and justice does not mean those values will necessarily be on the screen of bureaucrats whose priorities are cost-containment and, above all, an uncritical acceptance of neoliberal, market-based approaches to most social goods. Close study of *World Development Reports* of the past four years indicates that, despite the World Bank’s shift

to a poverty agenda and its recent emphasis on “community needs” and “partnership with key stakeholders” (Evers and Juárez, p.41), the assumption of Bank-based “reformers” is that older principles of social solidarity and universal coverage are *dépassée*; that the private market (in services, medicines and insurance) is the best guarantor of both access and efficiency. The result of this worldview “is that vast areas of the (formerly) social sector are opened up for private investment and profit, a good part of which comes from public revenues [through subcontracting]; the market becomes the source of most services for most people; and those who cannot afford to pay (‘the most vulnerable’) are left to be protected by (often nonexistent) ‘safety nets.’ In other words, health care becomes essentially a two-tier system: a commodity for many (‘health consumers’) and a form of ‘public assistance’—or an unattainable luxury—for the rest” (Petchesky, 2000c).

The biggest problem with relying on privatization to meet basic health care needs is that the market has no built-in mechanism of *public accountability* to assure that standards of quality, universal access and non-discrimination are, in fact, met. In practice, if not in theory, then, “free market” systems obviate health care as a basic human right because human rights enforcement depends on reliable systems of public regulation and accountability, which is not the same as consulting community “stakeholders” (much less allowing individual consumers to “shop around,” the regulatory solution of classical economics). At best, for gender equality and sexual and reproductive health as human rights to have any reality in such a policy environment requires not only “political will” on the part of policymakers (Evers and Juárez, p.37) but constant vigilance on the part of women’s and popular health groups with regard to every issue that comes up—whether it be safe abortion, violence and abuse in clinics, HIV/STD prevention for young people, etc.

Moreover, the language used to describe “stakeholders” has a subtle but significant bearing on the form their “consultation” takes and whether or not, or how

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effectively, they are involved in setting priorities. Health “consumers” or “users” may be subjects of marketing research to find out what they are willing to buy or may be “consulted” about their product “preferences” or their evaluation of provider practices. But this is not at all the same as *communities mobilized on the basis of claims for social justice and human rights and organized to participate directly in both the design and the monitoring of services*. The example Evers and Juárez cite of the Women’s Health Care Office in São Paulo is quite illuminating here since it is precisely the outcome of a unique, 15-year alliance between a popular health movement based in poor urban neighborhoods and the strong feminist health organizations that exist in Brazil (see Diniz et al., in Petchesky and Judd, 1998). But this kind of social movement arises out of radical oppositional ideologies and practices, not consultations or “partnerships” with the World Bank.

I agree very much with Evers’ and Juárez’s emphasis on community—and especially women’s—participation in designing and monitoring sexual and reproductive health and HSR budgets and services.<sup>2</sup> Nonetheless, the precondition for such participation to be both effective and genuinely democratic is a robust, politically-conscious civil society.

### **The Limits of Sector-Wide Approaches and the Problem of Resources**

Finally, though Evers and Juárez suggest at a number of points that the commitment of HSR advocates to sector-wide approaches may be in basic conflict with the more holistic vision of Cairo and Beijing for sexual and reproductive health and rights, they never fully develop this idea. Going back to my earlier analysis of economic justice and the integral connection between sexual and reproductive health rights and a whole range of enabling conditions, it becomes clear that only multi-sectoral or cross-sectoral, not sector-based, strategies can ultimately translate those rights into public policies and programs. Evers and Juárez use the familiar example of clean water and

sanitation, clearly indispensable to sexual and reproductive health and good health in general. “[I]f cuts in expenditure by the Ministry of Health are accompanied by an increase (or better targeting) in investment in sanitation, particularly clean water,” they write, “and this results in increased access to clean water among the poor, the outcome for women’s reproductive health may actually improve” (p.20). But where is the justice in having to choose between clean water and sanitation and, say, condoms or emergency contraception? And what assurance is there, using the formulas of SWAPs and DALYs (disability-adjusted life years), or even “gender mainstreaming,” that vital components of sexual and reproductive health won’t be bartered away in return for water and sanitation?

Evers and Juárez acknowledge that sexual and reproductive health is “a multi-sectoral concern” and that the multiple rights and needs it embraces—including not only clean water and sanitation but education, transport, nutrition, food security, decent housing and freedom from sexual abuse and gender discrimination—“cannot easily be institutionalized in a SWAP” (pp.38 and 24). They stop short, however, of a strong recommendation to return to the kind of cross-sectoral thinking embodied in the 1978 Alma Ata Declaration<sup>3</sup> or to build on the Pakistan Social Action Plan, which they cite as a model of multi-donor, cross-sectoral programming.

The problem, they suggest, is that cross-sectoral approaches only seem to work on a micro-scale due to poorly functioning national health ministries (pp.44 and 46-47). Oddly, however, they never even raise the issue of inadequate resources or global inequities in the distribution of wealth. South Africa has the most extensive constitutional and legal guarantees of sexual, reproductive and health rights of any country in the world, along with vibrant civil society organizations working for their enforcement. Yet a government commission issued a report in 1999 finding that its public hospital system “is so short of cash that it lacks enough workers, medical equipment, ambulances, linens and medicine to provide proper care to the poor.” (*New York Times*, Nov. 16, 1999; Petchesky,

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2000c) Although South Africa's health ministry and managerial systems work far from perfectly, what does this report tell us about economic justice?

Clearly, innovative thinking is needed—not to adapt sexual and reproductive health to the narrow, technical formulae of SWAPs and DALYs, but to move health reform efforts in a more complex and holistic direction. The biggest barrier to such a move at the moment is not managerial inefficiencies within national health systems; neither is it the language or the technical apparatus of HSR. Rather, it is a more fundamental assumption underlying economic frameworks: that any reform must anticipate the limits of scarce resources, that “sustainability” means developing institutions and budgetary mechanisms that can operate within these limits (Evers and Juárez, p.39), and that the only way to increase resources is through free markets and growth.

If women's health groups became more adept in “broader systems-level thinking” (p.44), and even if they were in charge of health systems, they too would have to face problems of resource allocation and setting budgetary priorities. That is why more and more transnational women's NGOs in the post-Beijing era are concerning themselves with questions of global financing and resources—becoming involved, for example, at the national and local levels in budgets for women and the poor and at the international level in the UN process called Financing for Development (see [www.un.org/esa/analysis/ffd](http://www.un.org/esa/analysis/ffd) and the Women's Caucus Statement, available from [www.wedo.org](http://www.wedo.org)). Behind this involvement is a critical perspective on current globalization patterns that entail rapidly widening gaps between rich and poor within and among societies and an emphasis on unregulated trade and growth at the cost of social and economic justice. This critical perspective is missing from Evers' and Juárez's paper.

Ultimately, alternative approaches to the prevailing conceptual framework of HSR—and a return to the principle of “health care for all” *with* gender equality—must identify alternative sources of revenue that

will tap into the huge stores of wealth that global capital has concentrated in a few countries, transnational corporations and individuals. Women's groups, working in coalition with development and anti-poverty organizations, have focused on a variety of potential resource bases, including debt cancellation, taxes on international capital flows (Tobin or currency transaction taxes), demilitarization and participatory mechanisms to assure that the revenues acquired from such measures be channeled into health, education and other social goods. Such proposals are the result of an incipient international civil society participating in open, democratic UN proceedings.

In this respect, they contrast with private humanitarianism—whether of drug companies or the Gates Foundation—which remain discretionary and unaccountable to anyone. Without far-reaching redistributive policies at the global and national levels, health reforms in most countries will continue to focus on efficiency rather than human rights, and sexual and reproductive health will continue to be the loser in the process of budgetary and sectoral triage. An economic justice perspective on sexual and reproductive rights, including the full implementation of the Cairo and Beijing agendas, brings us back to this reality. ■

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## Notes

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1. This language was originally introduced by women's NGOs participating in the WSSD+5 meeting and then adopted and negotiated successfully by the South African delegation and the entire G77 plus China. See also the language of the Universal Declaration of Human Rights, Art. 25. Article 17(2) of the UDHR maintains that "No one shall be arbitrarily deprived of his [sic] property," but this leaves ample scope for national and international redistributive policies to create the necessary resource base to finance basic health care for all.

2. It is important to distinguish the role of women's health NGOs as independent advocates and monitors of health services from their role as alternative providers of services. The latter role raises numerous issues of funding, authority and public accountability, as with any private-sector providers (see Petchesky, 2000c for a fuller discussion).

3. The International Conference on Primary Health Care, held in Alma Ata (Kazakhstan) in 1978, not only declared "health for all people of the world" to be a "fundamental human right" but also defined primary health care in very broad, cross-sectoral terms encompassing development, agriculture, food, education, housing, public works and other sectors in addition to the health sector.

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# Human Rights Relating to Women’s Reproductive Health: Implications for Health Sector Reform

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## Introduction

Human rights standards affecting women’s reproductive and sexual health have evolved significantly in the past decade. Advances have been achieved primarily through the Cairo and Beijing Conferences and their follow-up meetings, international treaty bodies and regional human rights systems, and some national courts. The paper “Understanding the Links: Globalization, Health Sector Reform, Gender and Reproductive Health” by Barbara Evers and Mercedes Juárez<sup>1</sup> provides an opportunity to examine systematically the application of these standards to the process of health sector reform (HSR).

The paper considers the relevance of globalization for women’s reproductive health and rights in the context of health sector reform and identifies how gender perspectives might be used to lessen the burden on women’s sexual and reproductive rights. It defines globalization in economic and technological terms:

“For purposes of this paper, globalization is taken to mean the increased integration of national economies stimulated by the liberalization of trade and capital markets (foreign direct investment and financial flows across national boundaries) and rapid technological advances in international communication” (p.10).

Globalization can also be seen in normative terms. That is, how certain values, such as human rights norms, resonate around the globe and are applied to benefit women and their reproductive and sexual health. While Evers and Juárez look at the impact of HSR on women’s rights and the protection and promotion of their reproductive health, they do not consider how these human rights norms can be used to

ensure that HSR is undertaken in a way that protects women’s rights relating to their reproductive and sexual health.

This paper will explore how recent developments in international, regional and national protection of human rights to health and equality might be applied to the advantage of women’s reproductive and sexual health in the context of HSR.

The challenges of implementing the right to health are significant. As in the case of many other economic, social and cultural rights, the task of giving momentum to the right to health is just beginning, and there is no proven track record of success. The challenges of implementing rights to ensure equity in HSR are even more daunting. HSR is driven by determinations of economic efficiencies, but there is little understanding of how to apply human rights to ensure either respect for human dignity in the health system or equity in access to health services. Human rights historically have been applied to redress individual wrongs; only recently have efforts been mounted to invoke human rights to achieve systemic reform, and the results have been mixed. Some countries have more experience than others in applying human rights to address the violations of women’s entitlements to health care, but the achievements are vulnerable to setbacks.

## Human Rights Standards Related to Health Sector Reform

Human rights relevant to women’s reproductive and sexual health are found in international and regional human rights conventions and national laws and constitutions.

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Human rights—including the right to non-discrimination on grounds of sex, gender and race; the right to security of the person; the right to be free from inhuman and degrading treatment; and the right to health—gradually are being applied to require governments to address health needs. The challenge is to determine how achievements in other areas of health can be used to address the reproductive and sexual health needs of women.

Bodies created by international human rights conventions to monitor and promote their observance have been hard at work developing standards for applying human rights to improve health, health care and health systems and to remedy the underlying conditions that inhibit reproductive and sexual health. The standards are outlined in General Recommendations and General Comments. These documents elaborate on the meaning of particular rights expressed in the various conventions, in order to guide signatory states in submitting their periodic reports on how they are bringing their laws, policies and practices into compliance.<sup>2</sup> They include:

*i) CEDAW General Recommendation 24: Women and Health (1999)*

This General Recommendation, developed by the Committee on the Elimination of Discrimination against Women (CEDAW) which monitors compliance with the Convention on the Elimination of All Forms of Discrimination against Women, requires that states take a life-cycle approach to the promotion of women's health. It requires states to report on how they address factors that are different for women and for men, such as:

- Biological factors (e.g. their reproductive functions);
- Socio-economic factors (e.g. unequal power relations);
- Psycho-social factors (e.g. postpartum depression); and

- Health system factors (e.g. protection of confidentiality, especially for the treatment of stigmatizing conditions such as HIV/AIDS and domestic violence).

The Recommendation requires states to eliminate all forms of discrimination against women in the context of health and health care and to ensure that women can exercise and enjoy human rights and fundamental freedoms on the basis of equality with men. Equality requires that we treat like cases alike and different cases according to their differences. The Recommendation makes clear that where health systems neglect to provide health services that only women need—such as emergency contraception, obstetric care and treatment for obstetric fistulae or incomplete abortion—this is a form of discrimination against women, which states are legally obligated to remedy.

This legal obligation remains in force regardless of whether health services are delivered through public or private means. The General Recommendation explains: “The Committee is concerned at the growing evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health. They should include information on positive measures taken to curb violations of women's rights by third parties, to protect their health and the measures they have taken to ensure the provision of such services” (paragraph 17).

*ii) CESCR General Comment 14: the Right to the Highest Attainable Standard of Health (2000)*

The Committee on Economic, Social and Cultural Rights (CESCR), created under the international covenant of the same name, has issued a General Comment that explains that where essential health services are not reasonably available, accessible and

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acceptable, states are in violation of individuals' right to the highest attainable standard of health protected by the International Covenant on Economic, Social and Cultural Rights. The General Comment provides an important framework for explaining the appropriate steps states must take to achieve the full realization of this right.

Availability of services requires a state to ensure that functioning public health and health care facilities, related goods and services, and essential drugs are available in sufficient quantity. While the General Comment recognizes that the precise nature of the services to be made available will vary from country to country, it requires the provision of reproductive and sexual health services.

Accessibility of services has four overlapping dimensions:

**Non-discrimination:** Health services must be accessible to all, especially those citizens most vulnerable or marginalized, in law and fact, without discrimination on any of the prohibited grounds, such as sex, race/ethnicity and age.

**Physical accessibility:** Health facilities and services must be within safe physical reach for all members of the population, including vulnerable or marginalized groups such as ethnic minorities and indigenous populations, women, children, adolescents, persons with disabilities and persons with HIV/AIDS.

**Economic accessibility (affordability):** Health services must be affordable for all. Payment for health care services must be based on the principle of equity, ensuring that services, whether privately or publicly provided, are affordable for all, including socially-disadvantaged groups.

**Information accessibility:** All persons have the right to seek, receive and impart information and ideas concerning health issues.

Acceptability requires that health services are ethically and culturally appropriate, i.e., respectful of the

cultures of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, designed to respect confidentiality as required in different cultures and to improve individuals' health status as they assess it.

General Comment explicitly requires states "to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services" (paragraph 35). Quality requires that health facilities and services must be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically-approved and unexpired drugs, and adequate, safe and reliable hospital equipment (paragraph 12). Moreover, the Comment specifically requires governmental representatives in international financial institutions, such as the World Bank, to ensure that lending policies and credit agreements guarantee respect for the right to health (paragraph 39).

Much work is still required to ensure laws, policies and HSR are designed and implemented to guarantee availability, accessibility, acceptability and quality of reproductive and sexual health services. This General Comment, however, provides an important road map to begin the journey.

*iii) HRC General Comment 28:  
Equality of Rights between Men and Women (2000)*

The Human Rights Committee's (HRC) General Comment on Equality between Men and Women requires that states ensure that women exercise their civil and political rights on the basis of equality with men. The General Comment explains how this is to be done with respect to each right protected by the International Covenant on Civil and Political Rights, which the HRC monitors.

For example, with regard to women's equal right to life, the Committee requires states to provide "data on birth rates and on pregnancy- and childbirth-related deaths of women" and "information on any measures taken by the State to help women prevent unwanted



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pregnancies and to ensure that they do not have to undertake life-threatening clandestine abortions” (paragraph 10).

With regard to the right of women to be free from torture and from cruel, inhuman or degrading treatment, the General Comment explains that the Committee needs “information on national laws and practice with regard to domestic and other types of violence against women, including rape. It also needs to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape. The States parties should also provide the Committee information on measures to prevent forced abortion or forced sterilization, and in States where the practice of female genital mutilation exists, information on its extent and on measures to eliminate it should be provided” (paragraph 11).

By requesting this kind of information, the Committee is incorporating notions of reproductive and sexual health into the content and meaning of the right to life and the right to be free from torture and inhuman and degrading treatment. In other words, how women experience their sexuality and the degree to which they can protect their reproductive and sexual health indicate the degree to which they can exercise these rights.

*iv) CERD General Recommendation 25: Gender-related Dimensions of Racial Discrimination (2000)*

The Committee on the Elimination of Racial Discrimination (CERD) has made a General Recommendation on Gender-related Dimensions of Racial Discrimination. This indicates to States parties to the International Convention on the Elimination of All Forms of Racial Discrimination, which the Committee monitors, that the Committee will examine the intersections of race and gender discrimination in reviewing governmental reports. To this end, it requests information on:

- The forms and manifestations of racial discrimination;

- The circumstances in which racial discrimination occurs;
- The consequences of racial discrimination; and
- The availability and accessibility of remedies and complaint mechanisms for racial discrimination.

The Committee therefore needs to know about such manifestations of racial discrimination as forced sterilization or forced continuance of unwanted pregnancies because of the women’s race or ethnicity.

*v) Supplemental Materials*

Some additional recommendations are useful in the health context, such as CEDAW General Recommendation 19 on Violence against Women.

In addition to the standards developed by the above treaty monitoring bodies, the United Nations High Commissioner for Human Rights and the Director of the UN Joint Programme on AIDS (UNAIDS) brought together relevant stakeholders to develop International Guidelines on HIV/AIDS and Human Rights. These guidelines, published in 1998, offer concrete suggestions for protecting human rights in the context of HIV/AIDS.

Regardless of the dedicated efforts of the various Committees, there has not been sufficient time for the above Recommendations, Comments and Guidelines to become part of the practice of the respective treaty bodies, particularly as they conduct their dialogues with reporting governments and the treaty committees draft their resulting concluding observations on governmental reports.<sup>3</sup>

In addition to the development of standards through international treaty bodies, regional human rights systems<sup>4</sup> and national courts are beginning to include health concepts in explanations of the content and meaning of rights, including: the right to life and survival;<sup>5</sup> the right to security of the person;<sup>6</sup> and the right to be free from inhuman and degrading treatment.<sup>7</sup>

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## Human Rights Needs Assessments

A necessary step in applying human rights to advance women's sexual and reproductive health is an assessment of the scope, causes and consequences of reproductive and sexual ill-health in a particular community or culture, based on available data or on the collection of relevant new data.<sup>8</sup> Local assessments should identify laws—including the statutory language and court decisions, as well as the policies of governments, health care facilities and other influential agencies—that facilitate or obstruct availability of and access to reproductive and sexual health services. A determination should be made of the extent to which laws that would facilitate access are actually implemented and how their implementation might be improved. Laws and policies that obstruct women's autonomy and choice in decisions regarding their reproductive and sexual health and the availability of services should also be identified, along with laws that facilitate or obstruct women's empowerment.

Assessments are needed of how countries can foster compliance with human rights at different levels, including clinical care and health systems, as well as the underlying social, economic and legal conditions.

These levels are not necessarily distinct. Often, there is overlap: failure to respect women's human rights at one level can exacerbate problems at another. Examples of application of human rights to clinical care, health systems and underlying health conditions include, but are not limited to, the following:

### Clinical Care

An assessment of the degree to which women's human rights are respected in the context of clinical care might show lack of respect for women's dignity and women's judgment of their circumstances. Women's rights of privacy in the delivery of reproductive and sexual health services are often ignored. Health care providers need to be trained in the importance of maintaining confidentiality of women seeking and receiving services. Breaches of confidentiality are

violations not only of service providers' professional ethical responsibilities, but also of the laws on patient confidentiality.<sup>9</sup>

There is need to assess how well clinical care handles diseases or conditions specific to or more prevalent among certain subgroups of pregnant women, such as malaria, sickle-cell trait, hepatitis and HIV/AIDS. Steps need to be taken to ensure not only that requested abortion services are provided to such women, but also that these underlying conditions are treated or that affected women are referred for appropriate treatment. Addressing such health problems among women in nondiscriminatory, constructive ways is a challenge. There is also a need to examine clinical manifestations specific to certain subgroups of women, such as domestic violence resulting in unwanted pregnancy. Emphasis should be given to finding ways to reduce the stigma of victimization in the clinical care context by ensuring respectful treatment of all women seeking services regardless of their circumstances.

### Health Systems

An assessment of the degree to which women's rights are respected throughout the health system might be approached through an examination of systemic barriers to the availability of care and of laws, policies and practices that might deter women from seeking care.

1. There is a need to examine the barriers to availability of reproductive and sexual health services, such as:

- Lack of implementation of laws and policies that are beneficial to women's health, such as, failure to provide legal abortions in cases of pregnancy due to rape;
- Lack of skilled health personnel capable of performing medical procedures due to legal prohibitions or restrictions (health personnel's abuse of conscientious objection to participation in lawful services falls under this point);

- Low priority given to sexual and reproductive health services in health facilities or in allocation of necessary governmental or other budgetary resources;
- Gender barriers such as scheduling institutional services at times inconvenient for women and lack of facilities to care for their children while they receive services; and
- Health laws and policies that require excessive qualifications for health care providers to provide reproductive and sexual health services.

2. There is a need to examine the existing and emerging deterrents to access to available reproductive and sexual health services for women or certain subgroups of women, such as:

- Lack or perceived lack of protection of confidentiality;
- Poor quality of care, including providers' disrespectful or punitive attitudes;
- Spousal, or other third-party, authorization requirements;<sup>10</sup>
- Failure to treat adolescent girls according to their "evolving capacity" to exercise mature choice in reproductive and sexual health care;<sup>11</sup>
- Payment or co-payment requirements, particularly for adolescent girls; and
- Language and cultural deterrents.

## **Underlying Conditions, Including Social, Economic and Legal Conditions**

Barriers to improving women's reproductive and sexual health are often rooted in social, economic, cultural, legal and related conditions that violate women's human rights. A human rights needs assessment might describe the effects of low levels of literacy and lack of educational or employment opportunities in denying young women alternatives to early or repeated pregnancy and in denying them economic and other means of access to reproductive and sexual health services. Women's vulnerability to sexual and other abuses, in and out of marriage, increases their risks of unsafe pregnancy and mental illness.<sup>12</sup> Social, religious and economic customs become embedded in the law and historically have been invoked to justify discrimination against women. A gender-sensitive approach to social science and legal research can identify how underlying social and legal conditions can influence women's independence and access to safe abortion services.

A human rights needs assessment will examine the underlying conditions that increase risk factors for reproductive and sexual ill-health that are common to women or certain subgroups of women. These conditions include: violence against women; sexual abuse; poverty; different forms of discrimination against women; and social conditioning of women's powerlessness.

Several comparative studies provide information on laws in various countries and regions.<sup>13, 14</sup> Legal research can help to identify how laws advance or compromise women's interests in their personal, family and public lives and their indirect effects on women's health. For example, family law frequently expresses communities' basic cultural values, such as rights to inheritance of land. Cultures resistant to women's equality with men have often unconsciously perpetuated women's subordination and powerlessness. They consider women's subordinate status a "natural" condition of family life and social order so profoundly as to render women's disadvantage invisible. Where

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women's subordination and powerlessness are perceived, they are considered not just a feature but a necessary requirement of the maintenance of social order and stability.

Laws that entrench women's inferior status to men and interfere with women's access to health services seriously jeopardize efforts to improve women's health. These laws take a variety of forms—obstructing economic independence by impairing women's education, inheritance, employment or acquisition of commercial loans or credit—but they all infringe on women's ability to make their own choices about their lives and health.<sup>15</sup> Criminal laws that condone or neglect violence against women should be considered, as well as inequitable family, education and employment laws that deny adolescent and adult women alternatives to marriage and that condition women's self-realization to marriage and motherhood.

Research also should determine whether laws adequately protect girls and women from sexual coercion and abuse. Studies show that forced first intercourse is prevalent in many communities, affecting up to 32% of girls and women.<sup>16</sup> Laws that inadequately protect girls and women from coercion in sexual relations undermine women's autonomy by obstructing their ability to protect themselves from unwanted pregnancies. Laws must be identified and enforced that allow women effective self-defense and control over the timing and number of their births.

## Moving Forward

Those working in health sector reform to ensure respect for women's human dignity in the health system or for equity in access to reproductive and sexual health services might well be heartened by the development of human right standards. These standards can be used in a variety of ways:

- As a language/discourse that enables individuals and groups to claim the rights to which they are entitled on the basis of equality;

- As a means by which to foster states' compliance with human rights principles through national ombudspersons, national human rights commissions, and regional and international human rights reporting, complaint and inquiry procedures; and
- As an advocacy tool to hold governments accountable politically, socially and legally for any laws, policies or practices which do not comply with human rights principles.

A human rights needs assessment might show that the introduction of private insurance schemes or user fees could limit the access of poor or minority women, thus discriminating against them on grounds of sex and ethnicity. Stakeholder consultations might be more effective if the stakeholders were trained to apply human rights standards to secure equal access to health services, including private sector services. The appointment of a "Health Ombudsperson" could ensure that human rights are protected and promoted throughout a country's or area's health services. Human rights NGOs could be trained to apply these rights to health issues, specifically reproductive and sexual health issues, and to apply the appropriate human rights procedures. ■

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## Rhetoric and Reality of Health Reforms: Implications for Reproductive Health and Rights

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A rights-based approach towards health sector reform is new. Its success depends upon gathering a body of evidence on how reproductive health and rights are faring within these reforms. In their paper for the Ford Foundation's Reproductive Health Affinity Group, Evers and Juárez eloquently lay out the rationale of such an analysis. I will highlight below some key issues involved in these reforms and their implications for reproductive health and rights issues, using evidence gathered from a case study conducted by CHANGE in Zambia.

The structural nexus between poverty, lack of social and economic entitlements, gender and ill health have been adequately documented and discussed and have been incorporated into policy imperatives, such as debt cancellation through the Highly Indebted Poor Country initiative or World Bank and IMF country strategies for poverty reduction (Sen, 1999; Harcourt, 2000). Within this context of health and development initiatives, health reforms are seen as a means of addressing health and poverty from the supply side, that is, through "changing the response of the health system to the needs of poor and vulnerable" (Harcourt, 2000). The reproductive health and rights agenda, on the other hand, addresses both the demand and supply sides of the poverty-health schematic: improving health care delivery and transforming target-oriented family planning programs while simultaneously addressing the empowerment and well-being of all individuals, especially women. On the surface, the priorities of the reproductive health rights agenda and those of the health sector reforms are somewhat parallel. However, there is very little evidence of how reproductive health priorities and gender equity concerns fare in the context of reforms.

In light of the sparse data that exist on the implications of health reforms for reproductive health and rights,

I first would like to draw an analogy with micro-credit programs. In the last decade, micro-credit programs seemed to be a panacea for poverty alleviation and the improvement of the health of families. Such programs primarily target women because of the apparent benefits for women's economic and social capital and the improvement of their own and household health. However, once cleansed statistically of selection bias, women's participation in credit programs has only a very small positive effect on their economic empowerment and *their own* health-seeking behavior (Nanda, 1998). This does not mean we should not give credit to poor women. *However, we need to carefully evaluate the results, compare them with our original expectations and consider the enabling environment for these policies and programs.* Any one development or reform program alone is never a magic bullet, especially when such programs fail to address why and how women are poor, why women are drawn to such programs, or what women do with the very small capital they manage to accumulate.

Almost all countries facing diminishing global and national resources for health and the dual burden of infectious and non-communicable diseases—even some developed countries, such as the United States—need some sort of health reform. In addition, many of these countries face deteriorating or low-performance health systems that cannot respond to the burden of increased morbidity from new and re-emerging diseases. The 1990s have already witnessed two generations of health reforms (Standing, 2000), and the language employed in the reforms has moved closer to the goals of poverty alleviation and empowerment. The rhetoric of reforms is now more progressive and shares certain values with the reproductive health and rights agenda (Evers and Juárez, 2001; Nanda, 2001).

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In practice, however, the ICPD agenda has not been integrated into either the logic or the implementation of reforms for two reasons: in many cases, health sector reforms preceded the ICPD mandate; and in addition, policymakers are often resistant to including reproductive and sexual health and rights into the national health systems. In fact, as currently conceptualized and implemented, reforms may do more harm than good. As in the case of micro-credit programs, health reforms are unarguably necessary but not sufficient. A successful health reform process is inter-dependent on overall developmental efforts in a country.

In order to clarify the inconsistencies between rhetoric and reality in health reforms, we need to ask a number of questions: who has access to formal health care, and whose health is being reformed? What aspect of that health care system is being reformed, and how will it be done? Who participates in decision-making about health reforms? Who are the poor and vulnerable, and how will they most benefit from these reforms? These queries expose several gaps between the theory and practice of health reforms that are best articulated as conceptual, implementation and perception gaps. I will address these gaps, drawing upon examples of how reproductive health and gender equity may be affected through current health reform efforts.

**Conceptual gaps:** True respect for gender equity and democratic values requires a shift in the power balance within the health care system. Initiatives to facilitate the reform processes, such as decentralization, imply a dramatic change in the *status quo* of power. Such transitions are not easy.

In Zambia, a Gender in Development Division within the cabinet was formed as the nerve center for all governmental policies on gender issues. However, the division's two senior staff have seemingly little decision-making power at the donor/national level or at the ministerial level. One of the challenges they face is resistance from top government officials to changing gender norms. For example, a local news report

from 1999 states that in a parliamentary session, heated debates took place in which some male parliamentarians accused their female peers of "not keeping their homes in order." Incidents like this raise concerns about the way these transitions are enforced. Since resistance to changing gender norms is often found among the top-most levels of hierarchical systems, simply forming new administrative structures or writing new policy guidelines can do little to advance reforms (Nanda, 2000).

Similarly, power imbalances have to be conceptualized wherever they appear: for example, at the district level (between district health teams and district administration in Zambia and Tanzania); between providers and clients (especially if we expect women clients or adolescents to exercise their rights to safe sexual health care); and between men and women within a household (as seen in women's covert use of contraception and the potential consequences of sexual coercion and violence when they use these services, especially fee-contingent health care). Reforms must identify and describe these power inequities and address how to correct them; otherwise, the reform process assumes implicitly that the problems are only technical and merely require technical solutions, despite the acknowledgment of structural influences.

**Implementation gaps:** At the level of implementation of reforms there are other concerns, including: the lack of capacity among local bodies to set priorities and manage health delivery systems; the inability of representatives of civil society to debate sector reforms and reproductive health and rights; the lack of adequate data to set health care priorities; the lack of consistent standards for quality of care; the lack of mechanisms to ensure accountability; and the lack of understanding and systematic training on reproductive health and rights. Despite the best intentions, current efforts to reform health systems may not achieve their goals of improved access and equity in health care services, let alone the broader goals of a reproductive health and rights agenda.

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**Perception gaps:** The varying perceptions of reforms by different stakeholders can put two other sets of issues into sharper relief: first, there is often a glaring contradiction in the reforms between the ostensible, *normative* aspects and what *really* occurs. A related issue is the frequent lack of transparency in decisions about the execution of the reform process and the lack of inclusion both of those who are charged with implementing reforms at the service-delivery level and those to whom reforms are theoretically accountable. These issues are most relevant when reforms have a previous baggage—such as adverse consequences of previous structural adjustment policies—or where reforms include a new language or a new intent to address issues of deterioration in the public health care system. In Zambia, health care providers stated that they felt left out of decision-making around reforms and often did not understand fully why certain reforms were being undertaken, e.g., user fees in the context of immense drug shortages, high HIV prevalence and highly-flexible and unremunerated women’s work. The lack of participation or inclusion in health reforms often leads to demoralization among health system staff, especially when they already face low wages and limited training, capacity and skills.

In conclusion, documenting the experiences of countries undergoing health sector reforms while simultaneously attempting to fulfill the goals of the reproductive health and rights agenda is critically important, especially for poorer countries in the early stages of reforms. A key element to improving the impact of health reforms for reproductive health and rights issues is better global governance for health, increasingly recognized as a crucial factor in ensuring better health outcomes, especially for those who are most in need and most disenfranchised. In order to address these issues, institutions that engage in research and debate health reforms from a gender, equity and rights perspective need to:

- Strengthen civil society’s access to information and its capacity to engage with institutional actors;

- Promote stronger regulatory frameworks to monitor health reforms;
- Develop evidence-based research on implications of current health reforms for the reproductive health and rights agenda;
- Monitor the implementation of key international mandates;
- Ensure greater sharing and dissemination of knowledge; and
- Promote opportunities for consensus building and transparency in decision-making on health reform processes. ■

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# Incorporating Women's Health Concerns in Health Sector Reforms: Key Areas for Strategic Advocacy and Citizen Participation

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In the last 15 years, health sector reform (HSR) has become an integral part of the larger structural reform process. Similarly, in the post-Cairo era, most countries have adopted reproductive and sexual health as a priority. In their paper prepared for the Ford Foundation's Reproductive Health Affinity Group, Evers and Juárez rightly point out that the main challenge facing women's health advocates around the world is how to put women's health and women's rights on the HSR agenda and how to ensure that a gender-sensitive and equitable perspective informs HSR processes. While most players in the HSR arena theoretically acknowledge the importance of a gender-equity and poverty focus in institutional reform, these issues are not woven into the fabric of HSR. At best they remain at the level of good intentions.

The unfortunate reality is that HSR is led by economists and technicians who do not always see poor people and women behind the smokescreen of statistics, organizational charts and figures. Therefore, women's health advocates—especially those who have been part of the Cairo process—stress *strategic advocacy to incorporate gender and equity issues in HSR*.

A first step in this direction is to make country-specific lists of institutional constraints to the implementation of reproductive and sexual health programs and projects and to analyze whether these systemic issues have been addressed in HSR.

For example, the South Asian experience has shown that paramedical workers are the mainstay of our health delivery system: only they can bring services to poor women in both rural and urban settings.<sup>1</sup> Therefore, enhancing clinical and diagnostic skills of nurse-midwives and technical/lab assistants (for diagnostic support) should logically be a priority.

Experience has shown that improved skills lead to greater self-confidence, community acceptance and effectiveness. Status, skill (especially clinical skills), attitude and the larger work environment of paramedical service providers are closely linked to the quality of medical education available to all health care professionals, from paramedical workers to fully-trained specialists and surgeons. Highly-qualified doctors are *neither available nor essential* for the first level of services. The primary bottleneck is *availability and accessibility* for poor users, especially rural women. Basic availability of service providers where women most need health care—in rural areas and urban shantytowns—is not given priority in HSR. The end user, the intended beneficiary of public health care services, has the least access.

Among the important issues flagged for action in reproductive and sexual health programs is quality of care—not only medical and technical protocols to ensure safety, but attention to basic facilities that provide an atmosphere of dignity, privacy and confidentiality at every service delivery point. Unfortunately, infrastructure development has been plagued with corruption and sub-standard facilities and equipment. Inviting community participation and private cooperation for construction, maintenance, supplies and non-medical support to health posts is known to be effective. Most advocates agree that meaningful partnership through a representative committee at the operational level not only enhances the quality of services but also involves women at the design and planning stage to resolve issues of privacy and essential facilities such as bathrooms. In this way, HSR can be more a *people-centered* process rather than an *economist- or demographer-driven* restructuring program concerned with reducing public expenditure or “controlling” population growth.

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Although every country at the International Conference on Population and Development signed the Programme of Action, HSR advocates are not convinced they need to adhere to the Cairo mandate. For example, most HSR advocates are concerned about problems that result from instituting user fees when basic minimum standards of care and accountability of service providers are not ensured.

At the same time, most HSR proponents acknowledge the importance of stakeholder participation at all levels and stages of the health delivery system. They also recognize the problem of operationalizing this participation in diverse social and political contexts. In particular, women's participation is not easy in societies where women's education, mobility and access to public spaces are limited. While statute-mandated committees and community fora are needed for meaningful participation, they alone are not enough. Investing in building the capacity of rural women leaders to help them negotiate the health delivery system from a position of strength and to make informed choices should be factored into HSR strategies to encourage stakeholder participation.

Evers and Juárez have flagged a number of gender, equity and mainstreaming issues. I agree with their position and endorse their work, and I would now like to move on to exploring effective advocacy strategies. How can we establish the legitimacy of these issues in the ongoing discourse on HSR? What kind of strategic advocacy would work in diverse political and administrative environments?

At the outset, it is important to acknowledge that *it is people who can forge convergence—systems and checklists alone are not enough*. Creating a core group of women's health advocates within institutions engaged in HSR and among professionals/experts working on HSR could be a promising first step. We have a lot to learn from the environmental movement: *creating and disseminating a body of knowledge has to go hand-in-hand with careful nurturing of advocates in governments, international agencies, the media, the research community and, above all, the community*. Reinforcing and strengthening these advocates

by enhancing their knowledge, skills and confidence to interact with other disciplines pays rich dividends.

*Sustained research is needed on systemic barriers to women's access to health services, as well as targeted dissemination of this research leading to an exploration of how ongoing HSR has addressed systemic issues*. Unfortunately, the mandate and funds for such research are limited as most commissioned research of the multilateral and bilateral agencies continues to be compartmentalized.<sup>2</sup> Acknowledging the interlinkages is perhaps the first step towards building bridges.

It may be recalled that *research-based advocacy* played a critical role in fighting the invisibility of women's work in the economy; the feminization of poverty; reproductive tract infections and women's vulnerability to sexually transmitted infections, including HIV/AIDS; and most importantly, the health impact of domestic and social violence. Using research as an advocacy tool could be effective if it is combined with a sustained dissemination plan, especially to key opinion-makers and leaders in the field.

In both the research and implementation stages, the distinct worlds of health sector reform and women's health rarely converge or intersect. Most often, different experts engage in reviewing, studying and planning for the two fields: the HSR group is comprised primarily of economists, demographers and health and hospital management specialists. Inviting them to join with women's health advocates to examine the systemic barriers to poor women's access to essential health care services and reproductive health could enable us to forge effective partnerships.

But a word of caution is in order: experiences in India and Bangladesh have shown that in the absence of a holistic approach such efforts may be ineffective. For example, getting a management expert to look into logistics and supply of contraceptives in a reproductive health program would be of little use unless it is part of a comprehensive assessment of the supply side, the service provider and the user.

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Interacting with women (users/potential users) and talking to them should be an essential part of such an undertaking. For example, assessment of personnel management, deployment of staff and the relationships among different categories of service providers should include an assessment of roles, responsibilities, attitudes, behavior, skills and capacities of physicians, administrators and paramedical workers of both sexes. Hilary Standing argues that gender relations in the health delivery system are known to be inhibiting factors in service delivery.<sup>3</sup> Factoring this aspect into HSR could be done through partnership research, assessments and reviews.

Issues of poverty and social justice need to be brought to center stage in HSR, especially in the highly-stratified societies of South Asia. This can be done only through active citizen involvement. Formation of user groups and women's groups are undoubtedly valuable. In the past five years, the movement for transparency and accountability in India also has generated some interesting possibilities. Supporting a public audit of availability, accessibility and quality of women's health services could indeed encourage community groups to initiate similar processes.

Presently, HSR is initiated at the national level and carried out in separate but parallel activities within hospitals, in the logistics of drugs supply, and to a lesser extent in other areas. Efforts to introduce user fees, health insurance and other alternative mechanisms for resource mobilization have been initiated from above. "Action projects"—such as community-based assessment of outreach and impact or service users profiles and their impact on quality—could help women's health advocates generate alternative information that could be fed into advocacy efforts and the media.

Reaching out to grassroots organizations and helping them to initiate community-based audit or assessments, then feeding this information back at the national level and further collating them at regional levels could indeed be an effective advocacy tool—especially with bilateral and multilateral agencies (including the World Bank and ADB). For sustained

impact, national advocacy has to be supported by international advocacy. It is important to communicate to policymakers and key actors that there is another way of looking at HSR: "From the perspective of poor women and men and the thousands of under-skilled and disempowered service providers, HSR should take a worm's-eye view and not a bird's-eye view of the systemic changes that are necessary to make the system work."<sup>4</sup>

Looking at the health delivery system from below and exploring how services can be brought to those hardest to reach is perhaps the only way effectively to incorporate women's health concerns into health sector reforms. The main thrust of strategic advocacy should be to bring about this important change. ■

## Notes

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1. Lack of midwives was identified as a major constraint in ensuring maternal health services for poor rural women in Bangladesh. While extension workers provide family planning services, there are no trained nurse-midwives in the government program. Vimala Ramachandran, "Mainstreaming Gender in the Health Sector—Reflections on South Asian Experience," mimeo prepared for SHAPLA training, Dhaka, Bangladesh, February 2001.
  2. It would be interesting to do a quick inventory of the research commissioned under the aegis of health sector reform and compare it to that undertaken on sexual and reproductive health.
  3. Paper presented at the Regional Meeting on the Gender and Reproductive Health Impacts of HSR, Lijiang, Yunnan, China, March 12-17, 2000.
  4. Vimala Ramachandran, "Another Perspective on Health Sector Reforms," *Seminar* (New Delhi) 489, June 2000.
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# Appendices

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## Appendix 1

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In 1999, CHANGE initiated a multi-country research project which seeks to understand the implications of health reforms for reproductive health and rights. Initially, this research is to be conducted in two countries: India and Tanzania. The two Indian studies (in Kerala and Tamil Nadu) focus on processes of decentralization, and the Tanzania study will examine user fees and community health funds. Field instruments and training of field investigators are currently being conducted, and data collection will begin in December 2001. The studies will be completed by September 2002. Also useful is the CHANGE/Population Council report from the 1998 meeting of the Working Group for Reproductive Health and Family Planning, published as *The Implications of Health Sector Reform for Reproductive Health and Rights* (see the annotated bibliography, Appendix 7).

## Appendix 2

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Website: [www.sn.apc.org/whp/](http://www.sn.apc.org/whp/)  
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The Women's Health Project is an independently-funded, non-governmental organization. One aspect of their work is to look at the linkages between health sector reform and reproductive health. In this effort, WHP has produced a manual of methodologies for a gender-sensitive, situation analysis of health services (particularly reproductive health services). WHP also has done considerable work on advocacy for policy change and the role of mobilizing women's voices. For example, the "Health Workers for Change" studies involve developing methodologies for the process of integration of reproductive health and general health services, participation of clinic-level health workers in decision-making on policy issues within South Africa, as well as international lobbying. These studies are completed but not yet published.

In addition, former WHP Director Barbara Klugman is currently completing a project for the Women's Budget Initiative in South Africa in collaboration with a leading health economist, Di McIntyre. This endeavor focuses on the policy-making process; the extent to which policies and budgets are linked at national, provincial and local levels; the current process of decentralization (the establishment of a district health system); and new policies in specific "programs" such as maternal and child health or communicable diseases. Ms. Klugman has also prepared a review for the WHO Gender Working Group on the value of gender tools and guidelines (see the annotated bibliography, Appendix 7).

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## Appendix 3

### **Pan-American Health Organization (PAHO)**

Mailing Address: 525 Twenty-third Street, N.W.  
Washington, D.C. 20037-2895, USA  
Fax: (1-202) 974-3663  
Website: [www.paho.org](http://www.paho.org)  
E-mail: [gomezels@paho.org](mailto:gomezels@paho.org)  
Contact: Elsa Gómez

With Ford Foundation support, PAHO has begun the first attempt to incorporate a gender perspective into HSR in the region. The Women and Development Division of PAHO has been working for more than four years on a gender equity framework to address health sector reform and has effectively partnered with other government sectors, international agencies and NGOs for the development of health programs from an equity perspective.

PAHO's project, which has already begun in Chile and will be implemented next in Peru, is aimed at reducing gender inequities in health status, health care and participation in health work, mainstreaming a gender equity perspective in HSR. Their strategy seeks to identify and redress inequities by thoroughly documenting gender inequities in health and their relation to health sector policies; by democratizing information on gender inequities in health, particularly through providing data and evidence in order to inform policy decisions and empower advocates; and by assisting relevant stakeholders and civil society to institutionalize gender equity priorities into national policies.

## Appendix 4

### **HealthWatch Trust**

Mailing address: XC-1 Sah Vikas  
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Delhi 110 092 India  
Fax: (91-11) 242-9749  
E-mail: [rvimala@vsnl.com](mailto:rvimala@vsnl.com)  
Contact: Vimala Ramachandran, Managing Trustee

Formed in December 1994, HealthWatch is a network of voluntary organizations, women's organizations, researchers and development practitioners who monitor and advocate for effective implementation of the Cairo agenda in India.

## Appendix 5

### **Asian-Pacific Resource and Research Centre for Women (ARROW)**

Mailing address: 2nd Floor, Anjung Felda  
Jalan Maktab  
54000 Kuala Lumpur, Malaysia  
Tel.: (60-3) 292-9913  
Fax: (60-3) 292-9958  
E-mail: [arrow@arrow.po.my](mailto:arrow@arrow.po.my)  
Contact: Rashida Abdullah, Director

ARROW's purpose is to enable women to better define and control their lives. The organization strives for an improvement in the health status of women in Asia and the Pacific. Based in Malaysia, ARROW advocates for policy and program reorientation through the acquisition, production, and distribution of practical materials to individuals and organizations accessed through a strategic database developed for Asia and the Pacific. ARROW also monitors and evaluates change in policies and programs through regional action-research in partnership with women's non-governmental organizations involved in national and international advocacy.

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## Appendix 6

### Latin American and Caribbean Women's Health Network (LACWHN)

Mailing Address: Casilla 50308  
Santiago, Chile  
Fax: (56-2) 223-1066  
E-mail: [rsmlac@bellsouth.cl](mailto:rsmlac@bellsouth.cl)  
Website: [www.reddesalud.web.cl](http://www.reddesalud.web.cl)  
Contact: Esperanza Cerón Villaquirán

Since 1998, LACWHN has offered the International Course "Gender Perspectives in Health" as part of the Itinerant University project. Organized in partnership with academic institutions and activist groups in various countries throughout the region, this educational project focuses on the issue of "Gender, Globalization and Health Reform." To date, courses have been offered in Peru, Chile, Brazil, Bolivia, Uruguay, Costa Rica and Venezuela. In addition, LACWHN's quarterly magazines, the *Women's Health Journal* and *Revista Mujer Salud*, have published several articles on gender equity and health sector reform in the region and elsewhere (see *Women's Health Journal* 3/1997, 4/1998, 3-4/2000, and *Revista Mujer Salud* 3/1997, 4/1998, 3/2000, 4/2000).

## Appendix 7

### Annotated Bibliography

Baden, S. and H. Wach. 1999. "Gender, HIV/AIDS Transmission and Impacts: A Review of Issues and Evidence." Bridge Report No. 47.

This report features case studies on Bangladesh, Uganda and Brazil, as well as statistical data that summarizes the different patterns of infection and disease among men and women. The section on limitations and gender bias in existing data would make an interesting summary.

Beck, T. 1999. *A Quick Guide to Using Gender-Sensitive Indicators*. London: Commonwealth Secretariat.

This guide includes gender-sensitive indicators for the health sector. The indicators for sexual and reproductive health require further development. The information to assist governments and other stakeholders includes: an explanation of what gender-sensitive indicators are and why they are useful; pointers on interpreting indicators; suggestions for how to develop a national database of gender-sensitive indicators (data sources, methodological advice, training, participation); different areas to which gender-sensitive indicators can be applied (households, health, legal rights, etc.); and state-of-the-art data and indicators.

Botswana, The Government of. 1998. *National Gender Program Framework*. Gaborone: Government Printers.

The framework is an attempt at a multisectoral and coordinated response to gender issues which covers six areas, including women and health. Its main health objectives are: to increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services; to strengthen preventive programs that promote women's health; to undertake gender-sensitive

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initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues; to promote research and information dissemination on women's health; and to increase resources and monitor follow-up for women's health issues.

Butcher, K. and U. Kievelitz. 1997. "Planning with PRA: HIV and STD in a Nepalese Mountain Community." *Health Policy and Planning* 12(3):253-261.

The newly-created Department of Health Services within Nepal's Ministry of Health was intended to strengthen the District Health System. This article examines a pilot PRA exercise that analyzed not only services but also the role which local beliefs and practices might play in health-seeking behavior regarding HIV and STDs. The differences in concepts and opinions about sexual health among people of different ages, genders, classes and ethnicities are highlighted along with the sense of ownership that PRA can foster in the planning process.

Caudill, D. 1998. *Responding to Reproductive Health Needs: Participatory Approach for Analysis and Action, A Report and Training Guide on Experiences in Nepal*. Oklahoma City: World Neighbors Action Learning Group.

This report and training guide was designed to enable participants in "training-for-trainers" workshops to better understand reproductive health from a gender-sensitive perspective; to analyze their activities in terms of a gender approach; to gain skills in using participatory tools; and to develop an action plan for working with NGOs and women's savings and credit groups.

Chatterjee, M. and J. Vyas. 1999. "Organizing Insurance for Women Workers: The SEWA Experience." *Conference Report on Linking Women's Health and Credit in India: Program Experience and Future Action*. Program for Appropriate Technology in Health (PATH), New Delhi: January 20-22, 1999.

This report is a summary of SEWA's experience of providing women workers in the informal sector with an integrated insurance scheme that covers health as well as accidental death and loss. In addition to payment for hospitalization, several other health benefits are described, such as improved links with local doctors. As the scheme became well-known, some doctors offered their services at a reduced rate; the best local doctors could be identified and members referred. Cooperative groups related to SEWA started to run counters at hospitals selling rational drugs at a low cost. In addition, since reimbursement was dependent on hospitalization, women were more likely to have longer-term treatments than before, reversing the low priority given to their health within the family. The insurance scheme now needs to develop decentralized procedures, extend its outreach and coverage, and ensure that procedures are flexible and simple.

DGIS (Development Cooperation, Dutch Ministry of Foreign Affairs). 1999. "Sector-Wide Approaches for Health Development." *Focus on Development* (The Hague) 11, December.

This publication summarizes experiences of Dutch bilateral activities in health in a number of countries. Part I includes an analysis of the key components of sector-wide approaches in various countries, particularly those where a clear, comprehensive health plan or program of work exists. A chapter on lessons learned and current dilemmas helps to identify the present and future role of the Netherlands in the development of the health sector in order to improve the quality of health services. Part II includes fact sheets from 16 countries in Asia, Africa and Latin America.



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Enemark, U. and F. Schleimann. 1999. "Financing Health Services in Poor Countries: Feeding a White Elephant?" Discussion Papers No. 1, Copenhagen: DANIDA.

The authors challenge some of the basic assumptions related to health-care financing in development aid. With the exception of the poorest countries, the overall health-care expenditures seem to be sufficient for the estimated resource needs for the basic package of district health care. Yet realistically, only part of the resources can be made available for district health care. Illustrated with examples from five sub-Saharan countries in which DANIDA is involved, the study takes a comprehensive look at the health sector in terms of financing and service provision.

Gotez, A.M. 1997. *Getting Institutions Right for Women in Development*. London: Zed Books.

This collection of essays is divided into six parts: accountability to women; theoretical perspectives; institutionalizing gender equity in state bureaucracies; institutionalizing gender equity in NGOs; the role of individual agents; and women organizing for themselves.

Gujit, I. and K.S. Shah. 1998. *The Myth of Community: Gender Issues in Participatory Development*. London: Intermediate Technology Publications.

This collection of essays consists of critical reflections on the effect of the widespread use of participatory approaches on gender. There are three sections: theoretical reflections on participation and gender; practical examples from Asia, Africa, Latin America and the Caribbean; and examples of how organizations are integrating gender concerns.

Haslegrave, M. n.d. "The Role of NGOs in Promoting a Gender Approach to Health Care." UNDAW website: [http://www.un.org/womenwatch/daw/csw/role\\_ngo.htm](http://www.un.org/womenwatch/daw/csw/role_ngo.htm)

This article analyzes the importance of the advocacy role of NGOs in improving women's health care.

Hulton, Cullen and Khalokho. 2000. "Perceptions of the Risks of Sexual Activity and their Consequences among Ugandan Adolescents." *Studies in Family Planning*, 31(1):35-46.

This study aimed to discover adolescents' behavior, motivations and perceptions of risk with regard to pregnancy and HIV transmission and to propose possible solutions. The lack of young men's responsibility for the outcomes of their behavior as a barrier to achieving sexual health was highlighted, as well as the way in which young women are pressured into using their sexuality to achieve status and identity and to acquire material goods.

Jewkes, R. 2000. "Stepping Stones: Feedback from the Field." ActionAid's 'Strategies for Hope' website at <http://www.actionaid.org/stratshope/ssjewkes.html>

The Stepping Stones training program in Southern Africa was adapted specifically to deal with gender violence and communication, as this report explains.

Jimenez-David, R. and F. Tadiar. 1999. "Case Study of the Women's Health Care Foundation, Quezon City, Philippines." Family Health International website at <http://reservoir.fhi.org/en/wsp/wspubs/philippine.html>

This detailed study looks at the Women's Health Care Foundation and its 20-year history, during which it has served some 35,000 clients. The Foundation aims to move women's health care beyond maternal and child health to all phases of their life and

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works through three health clinics and community-outreach programs. The Foundation is also involved in advocacy and educational work that stresses: access and affordability; reaching communities through outreach clinics; providing women with information for empowerment; building partnerships with other NGOs and local businesses; and advocacy with government agencies.

Jing, F. 2000. "Participation: A Way to Better Health Outcomes?" In *Accountability through Participation: Developing Workable Partnership Models in the Health Sector*. IDS Bulletin 31, Brighton: IDS.

This article outlines two case studies aimed at improving women's health using participation. The first was a maternal and child health poverty subsidy program that focused on participatory planning among service providers, health officials and local government leaders. This successful program increased utilization of maternal and child health services by the poorest families and decreased the infant mortality rate. The second project involved integrating micro-finance with reproductive health improvement and had a less obvious outcome: the poor women involved were happy with their micro-finance activities and wanted to extend their groups; however, they did not take up the reproductive health element of the project, and no improvement in this areas was shown. Nonetheless, the women argued that a more stable financial situation made them less prone to poor health.

Kabeer, N. and R. Subrahmanian, eds. 1999. *Institutions, Relations and Outcomes: a Framework and Case Studies for Gender-Aware Planning*. New Delhi: Kali for Women.

This publication includes several essays on gender issues within the Indian bureaucracy. Of particular interest are the details of gender training carried out under the Gender Planning Training Project (Chapter 14).

Kambou, Shah and Nkhama. 1998. "For a Pencil: Sex and Adolescence in Peri-urban Lusaka," Chapter 10 of *The Myth of Community*, Gujit and Shah, eds., London: Intermediate Technology Publications.

This examination of CARE's initial participatory study—which gave rise to its adolescent sexual and reproductive health program—includes a gendered analysis of reasons for early sexual activity.

Klugman, B. 1999. "Mainstreaming Gender Equality in Health Policy." *AGENDA* (South Africa: University of Cape Town Gender Training Institute), Monograph in collaboration with African Gender Institute.

A section on gender equality in implementation of HSR assesses the experience of Health Workers for Change, a gender-sensitive WHO/TDR initiative to improve service delivery in treatment of tropical diseases.

Klugman, B. 2000. *A Critical Review of Tools for Mainstreaming Gender Analysis and their Application and Usefulness in Health*. Geneva: WHO, Gender Working Group.

Tools for mainstreaming gender analysis from AusAID, CIDA, Commonwealth Secretariat, DFID, ECLAC, Liverpool School, OXFAM, Royal Tropical Institute, SIDA, UNFPA, USAID and WHO are analyzed in terms of their relevance to gender analysis, research methods, programming, institutional change and health focus. Chapter Three discusses how these tools relate specifically to health, including the social construction of health and illness, health-seeking behavior, quality of care, health promotion, financing and participation. Chapter Four focuses on the user of the tools and what assumptions are made about her/his knowledge and experience. Chapter Five critically reviews each of the tools.

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Nduati, R., and Kiai, W. 1996. *Communicating with Adolescents on HIV/AIDS in East and Southern Africa*. Nairobi: Regal Press.

This review of programs specifically targeting youth with HIV/AIDS prevention activities divides the initiatives into risk reduction programs, media initiatives and combinations of the two. The analysis does not take a gendered approach but reports on the different successes of certain programs with boys and girls as well as single-sex programs, such as those run by the Girl Guides and the Scouts.

Oxaal, Z. with S. Baden. 1996. "Challenges to Women's Reproductive Health: Maternal Mortality." Bridge Report No. 38.

This report examines the medical, socio-economic, cultural and political factors affecting the outcome of pregnancy and includes many case studies. The report analyzes gender bias in the structure and culture of health service provision and examines reproductive decision-making. The chapter on effective strategies to lower maternal mortality is good as well as the appendix on statistical problems associated with measuring maternal mortality.

Ramachandran, V. 1995. *Engendering Development: Lessons from Some Efforts to Address Gender Concerns in Mainstream Programs and Institutions in India*. New Delhi: Educational Resource Unit, Jaipur.

This publication reviews the experiences of different gender mainstreaming efforts in government development programs and provides detailed suggestions for the critical steps that need to be taken to internalize gender in institutions.

Ramachandran, V. 1996. *Critical Consciousness, Credit and Productive Assets: Key to Sustainable Livelihood (Women's Mobilization in Nellore and Anantapur Districts of Andhra Pradesh.)* New Delhi: UNICEF.

This report develops a critical analysis of the sustainability of savings movements as development and gender interventions, analyzing the successes in the Podupulakshmi (savings movement) in Nellore and its impact on women's health.

Rubio, L., ed. 2000. "Equity, Participation and Consistency? The World Bank at Beijing+5." Mexico: Alcadeco, A.C.

This paper evaluates health and education reforms in ten countries, including projects which are interesting from a reproductive health perspective: the Maternal Child and Nutrition Program, Argentina; the Youth Development Program, Colombia; the Provincial Health Care Project, Dominican Republic; the program to expand health coverage in Mexico; the Nutrition, Education and Health Program, Mexico; the Basic Health and Nutrition Project, Peru; and the Health Care Reform Project, Venezuela.

Sen, G. 1999. *A Quick Guide to Gender Mainstreaming in Finance*. London: Commonwealth Secretariat.

This guide for policymakers, planners and personnel managers working in/with finance ministries covers: mandates for gender equality and equity in the finance sector; the changing role of Ministries of Finance; MOF and gender; engendering MOF; promoting attitudinal change; easing institutional constraints; and strategic areas of action.

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Stewart, S. 1998. *The Contribution of Gender Training to Equality between Women and Men in DFID Development Management*. London: DFID, Social Development Division.

This assessment of the impact of gender training with 95 DFID employees includes several key findings. Since senior personnel are under-represented in training, promotion should be made dependent on attendance. Men rather than women in the organization believe that gender interventions are interference in another culture: gender training needs to incorporate specific ways of dealing with this concern. Gender training is successful in sensitizing personnel to recognize when they need to call in the 'gender experts' rather than making them experts. And finally, the Social Development Division plays a central role in both championing gender as an issue and in providing expertise.

Tallis, V. 1998. "Counting the Cost of AIDS." *AGENDA* (South Africa: University of Cape Town Gender Training Institute) No. 39.

This article argues for a gender approach to AIDS. An analysis of the NACOSA AIDS Plan finds that while gender mainstreaming was a key principle, the interventions themselves did not adequately address gender. The gap between gender/women's organizations and AIDS organizations is highlighted, and women's differentiated vulnerabilities to AIDS—programmatic, social, reproductive and as caregivers—are summarized.

UNDAW. 1998. *Women and Health: Mainstreaming the Gender Perspective into the Health Sector*. Report of the Expert Group Meeting September 28-October 2, 1998, Tunis.

Section E of this report outlines good examples of intersectoral collaboration for gender equity. Examples of good practice include: PAHO's coordination prevention program on gender-based violence in ten countries; Sweden's application of Agenda 21 to integrating gender equity and environmental issues; national policies to achieve universal access to health care for women in Botswana, Cuba and the Netherlands; HIV and AIDS programs in Zimbabwe that use NGOs, the media, schools and government agencies; anti-smoking programs in the USA; and São Paulo's community health programs in which the municipal government provides free access to family planning.

### **Other Useful Resources on Gender and Health Sector Reform**

ARROW (Asian-Pacific Resource and Research Centre for Women). 1996. *Advancing the Women's Health Agenda in the Asia-Pacific Region*. ARROW Resource Kit, Working Group 1996 on Gender and Health, Kuala Lumpur, Malaysia: ARROW.

Aitken, I.W. Forthcoming. "Decentralization and reproductive health," in *Myths and Realities about Decentralization of Health Systems*. R. L. Kolehmainen-Aitken, ed., Boston: Management Sciences for Health.

BRIDGE. 1997. *Gender-aware Health Sector Reforms and Healthcare Provision: A Select Bibliography*. BRIDGE Bibliography 8.

CHANGE/Population Council. 1998. "The Implications of Health Sector Reform for Reproductive Health and Rights." Report of a meeting of the working group for Reproductive Health and Family Planning. Washington, D.C.: CHANGE/Population Council.

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- Standing, H. 2000. "Frameworks for Understanding Gender Inequalities and Health Sector Reform: An Analysis and Review of Policy Issues." Working Paper No. 99.06, Boston: Harvard Center for Population and Development Studies.
- Standing, H. 2000. "Gender Impacts of Health Reforms—The Current State of Policy and Implementation." Paper presented at ALAMES Meeting in Havana, Cuba, July 2000. *Women's Health Journal* (Santiago, Chile: LACWHN) 3-4/2000.
- WEDO. 1999. *Key Findings from Women, Environment, and Development Organization's (WEDO) International Study of Women's Health and Services, Risks, Rights and Reforms*. Can be ordered on-line at <http://www.wedo.org>

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