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Gender and Health Sector Reform

A literature review and report from a workshop at Forum 7

Lesley Doyal

Gender and health sector reform: a literature review and report from a workshop at Forum 7

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Mainstreaming Gender

at Forum 6

A briefing document and resource guide

Lesley Doyal

Introduction

The last two or three decades have been marked by complex and overlapping processes of reform in health care systems. These developments have been shaped by many economic, social and ideological pressures and their effects have varied in different settings. In the 1970s WHO led a push for greater equity through the growth of public health and primary health care initiatives. However the 1980s saw many of these in decline as a result of financial pressures and structural adjustment policies introduced by the World Bank and the International Monetary Fund. Many developing countries felt obliged to withdraw still further from what were already very limited public health care systems in order to acquire and then to pay back loans that they could ill afford.

By the late eighties and the early 1990s it was clear that these policies had not succeeded, that HIV/AIDS epidemics were spreading and that a global health crisis was emerging that could have far reaching effects. Led by the World Bank, a new approach to health sector reform was developed in response (World Bank 1993). This approach to reform focused on the demand as well as the supply side of health care delivery in order to improve efficiency and effectiveness as well as equity (Cassels 1995; Standing 2002).

Many countries (both rich and poor) adopted some variant of this overall approach in an attempt to use scarce resources to more effect in pursuit of improvements in public health. The specific policies deployed varied between settings but in most cases they included new methods of defining priorities, the development of a wider range of financing options, the delivery of cost-effective basic health packages, greater integration between services and the decentralization of decision-making (Berman 1995; Cassels 1995).

During the latter part of the 1990s, many of these trends were reinforced still further with the introduction of what were called "Sector-Wide Approaches" (SWAPs). For low- and middle-income countries these initiatives represented a shift from separately financed, individual project-based approaches towards the financing of health care on a more

integrated and sector-based model. They also placed greater emphasis on the idea of partnerships with key stakeholders in recipient countries including the private sector and NGOs. In return national governments and ministries of health were expected to ensure the more effective utilization of resources and the development of local capacity in the management and delivery of services (Kassels & Jankovsky 1998).

These different policy strands are often difficult to identify and disentangle in particular situations. However they clearly have the potential for improving the health of both women and men. If scarce resources can be used more efficiently and effectively, then they should provide better outcomes for individuals and populations. If they are focused on the needs of the poor, then they should also promote greater equity. However there is very little evidence on how far the policies are achieving their stated goals.

Overall, there have been few rigorous evaluation studies of health sector reforms (Blas & Hearst 2001; Blas & Hearst 2002). Indeed many commentators have pointed out that enormous changes have been put into place in the absence of a systematic body of evidence to demonstrate either the advantages or the pitfalls. There has also been a failure to measure the effects of health sector reform in different community settings and on different groups in the population. In particular there has been a failure to recognize that they might have very different effects for women and for men (Evers & Juarez 2002; Liverpool School of Tropical Medicine 2000; Nanda 2000; Onyango 2001; Standing 1997).

In 1994 participants at the International Conference on Population and Development (ICPD) in Cairo outlined a Platform for Action that focused on the sexual and reproductive rights of women. This included recommendations on how health services themselves should be improved but also highlighted changes that would be needed in the wider society. Central to their recommendations was the need for comprehensive systems of primary care including an essential package of reproductive health services as well as methods for tackling other health hazards such as violence against women. The recommendations called for services to be 'client centred' so that individual women and men could access the means to achieving their reproductive goals.

Many countries have been attempting to follow the Cairo Platform for Action while at the same time engaging in the broader processes of health sector reform (WEDO 1998). On the face of it, these two agendas have a great deal in common: both are based on a rhetoric of greater efficiency, improved health care and more equity. Indeed it is clear that the ICPD goal of sexual and reproductive rights could not be achieved at all without broader health sector reform (Krasovec & Shaw 2000). However there is sometimes evidence of conflict and contradiction. Too often health sector reforms seem to be based almost entirely on efficiency concerns while rights and equity issues receive little attention. Reproductive health issues in particular seem to slip down the agenda especially if they challenge existing social values (DeJong et al 2000; Lakshminarayanan 2003a; Langer et al 2000; Lubben et al 2002; Meachem 2002; Reproductive Health Matters 2002; Working Group on Reproductive Health and Family Planning 1999).

This resource briefing offers an overview of the existing evidence base relating to gender and health sector reform. It begins by examining the different components of these reform processes and why they might have different implications for women and for men. This will reflect both the different biological needs of the two sexes and also the influence of social or gender differences between women and men on health care needs and on access to services and their quality. While available evidence on different aspects of health care will be mentioned, the review will pay particular attention to sexual and reproductive services.

Components of health sector reform and their implications for gender and reproductive health

Approaches to health sector reform are varied with different countries starting from different places and emphasizing different goals. But most are operating in similar contexts of weak state capability, a small private sector and widespread poverty. Some may be radical and far reaching while others may be very limited in their approach. They can include a range of strategies, policies and interventions but the most common are new measures of cost effectiveness and resource allocation, innovations in financing, decentralization of management and reorganization of service delivery. The next section will examine what is known about the gender implications of these different but interrelated initiatives.

Measuring cost effectiveness and allocating resources

It has become commonplace for many countries undertaking health sector reform to base their planning on the burden of disease or Disability-Adjusted Life Years (DALYs) approach pioneered by WHO in the 1990s. Following the recommendations of the 1993 World Development Report, the aim has been to measure the burden of disease and then to allocate resources to gain the largest number of DALYs from a given expenditure. This certainly has some advantages as an evidence base for decision making. But in recent years a number of critics have also pointed out its limitations. They have highlighted the fact that the measurement of DALYs is usually based on the values of well educated professionals, that they take a narrow view of health focusing on specific diseases and that they overestimate the positive impacts of medical interventions (Fox-Rushby 2002).

Other commentators have highlighted the particular problems posed by DALYs in identifying the health needs of women (Hanson 2002). Women are significantly more likely than men to suffer from a number of different conditions at once. Many pregnant women will also have malaria for

instance and this overlap will not figure in DALY calculations. It is also clear that many women have experiences that may be damaging to their health without being discrete 'diseases' in the DALY sense. Many of their health problems or health needs are invisible, unaddressed, undiagnosed or asymptomatic with the need for family planning and the effects of violence and illegal terminations coming high on that list. Thus the epidemiological baseline for health sector reform may be significantly biased in relation to gender as well as other aspects of social differentiation among users.

Innovations in financing

Because these reforms are usually taking place in the context of scarce public-sector resources, new ways of financing them are high on the list of concerns (Kutzin 1995). The overall trend has been towards greater cost recovery from households though a number of different strategies have been used to achieve this. These include community financing and social or private insurance which is found most commonly in Latin America (Gomez Gomez 2002). But in many countries (especially in Africa) the introduction of user fees was the commonest approach. In some resource-poor settings these fees can be useful in increasing the availability of unrestricted funds. However a number of studies have shown that they can have a negative impact on the poor in general and poor women in particular (Hussein & Mujinja 1997; Moses et al 1992; Nanda 2002).

The rationale for the introduction of user fees has been that they would be able to release extra money to increase quality of care and that the majority of the poor would be able to afford them. However the evidence suggests that in many places this is not correct. User fees are usually regressive and inequitable since they require the poorest people to pay a larger proportion of their income in health care costs. When people do pay they often have to revise their small household budgets drastically. They may have to sell land or cattle and this can damage their future health and that of their families. Recent studies have examined the impact of these fees in different African countries and evidence from Ghana, Swaziland, Uganda and Zaire all showed a decline in service use by both women and men (Nanda 2002). But women seem to be especially severely affected.

This reflects in part the fact that women make up the majority of the poor in many communities and are therefore less able to find the necessary funds. A study from Ghana showed that many women found it extremely difficult to pay for care especially those who were widowed or single parents (Waddington & Enyimayew 1990). Those who were living in households with males may be given lower priority in allocating funds (Nanda 2002). It seems that fees affect women's use of all services but those connected with pregnancy and reproduction have been more extensively researched with maternity services being shown to be highly price sensitive.

A widely cited study of maternity services in Zaria, Nigeria found that the introduction of fees led to a 56% increase in maternal deaths while hospital deliveries fell by 46% (Ekwempu et al 1990). Another study in Kenya showed that the introduction of user fees equivalent to about half a day's pay led to a dramatic drop in the use of services for sexually transmitted infections for both women and men but when the fees were dropped women returned in larger numbers than before the fees (Moses et al 1992).

In some places maternity care and family planning are exempt but this does not apply everywhere. There is also evidence that where exemption systems are put in place for the poorest they are rarely effective either because they are complicated and inconsistent, because they are manipulated by workers and/or because clients do not know about them. (Nanda 2002). Again it is women who are most affected by this since they make up the majority of poor clients who would normally be eligible

There is very little evidence that user fees have really made a difference to the quality of care. They are expensive to collect and may cause great hardship Hence this aspect of health sector reform does not seem to have made a major contribution to the IPCD goal of extending high quality reproductive health care to all those in need.

Decentralization of management and control

A central theme of most health sector reform has been to move control down from the centre to the district level with the ministry retaining

responsibility for functions such as policy formulation, regulation, standard setting and technical support to the districts. The argument for this is that power and resources will be shifted nearer to users and to those providing the service. Hence the hope is that services will become more responsive to local needs with greater local ownership and accountability, as recommended in the rhetoric of both SWAPs and ICPD.

In some settings decentralization may indeed help to get users closer to services, as a recent study of the Women's Total Health Care Program in Brazil has illustrated (Araujo 1998). But again, the sparse available evidence indicates that these goals will rarely be met in practice. Greater equity may not be achieved because some districts are much poorer than others and will need additional resources that may not be forthcoming. It is also clear that time and patience are needed and changes such as this cannot be done in one quick move. Many district and local health services lack the capacity for the planning of services and this may take a long time to build up.

Again there is evidence that women may gain less than men from decentralization (Lakshminarayanan 2003b). This reflects the low status of women in many communities where they have little input into decision making in the health sector or elsewhere. This can lead to situations where very low priority is given to reproductive health services by local decision makers. A recent case study of decentralization in health care in Zambia showed that institutional capacity constraints at the local level, uneven political commitment and lack of community participation made the implementation of the reforms very difficult especially in the arena of reproductive health (Nanda 2000). Women may also be at particular risk when responsibility for drugs or contraceptive devices is devolved from a central store to local services.

Integration of service delivery

Health sector reform usually involves the redesign of patterns of service delivery. Central to this has been a debate about the integration of services that had previously been delivered separately. While this can be applied across the health sector there does appear to be an especially strong case for integrating sexually transmitted infections, maternal and child health and family planning programmes with those for HIV/AIDS. In some

countries benefits appear to have been achieved but in others they have not. Researchers in a number of countries including Tanzania, Bangladesh and Columbia have found that this potential has not been achieved in practice (Antarsh et al 2000; Askew & Maggwa 2003; Dehne, Snow and O'Reilly 2000; Mayhew 2000). There are a number of reasons for this.

At local level there is often a lack of qualified and specialist staff capable of taking over new responsibilities in the area of reproductive health. Especially problematic have been attempts to integrate HIV/AIDS and other sexually transmitted infections services with maternal and child health and family planning. A recent study in four countries in sub-Saharan Africa indicated that though collaboration did improve, vertical management and separate service delivery were still commonplace in most settings and practical integration was hard to achieve (Lush et al 1999). This has made it hard to tackle the growing HIV epidemic and continuing high rates of maternal mortality. The authors argue that either specialist services will need to be retained or there will need to be a much wider commitment to primary health care as in South Africa.

The wider implications of health sector reform for women's work

Most evaluations of health sector reform that have taken gender into account have focused on female users. However recent commentators have pointed out that they may also be affected as both paid and unpaid workers. Women are the major producers and the major consumers of health care and this needs to be understood if the gendered effects of HSR are to be fully understood (Standing 1998).

Women make up the majority of employees in all health care systems but they are not evenly distributed in the workplace. By and large men still make the decisions and the implications of these for female workers tend to go unnoticed. Health sector reform often involves changes in terms and conditions of employment including the improvement of incentive

structures, reducing overstaffing, changing pay grades and revising job descriptions. Where there are gender inequalities in the workforce, this offers an opportunity to redress the balance but there is little evidence of this being on the agenda. Rather it seems that women are more likely to lose out than men in the process of downsizing and to be given less chance to (re)train and progress (Standing 2002). Moreover those responsible for human resources have rarely recognized that the daily lives of male and female workers may be very different and that this will affect their employment needs.

At the same time health sector reform sometimes leads to less publicly funded care and a lower quality of care in the private sector. This means that a larger burden of unpaid care may fall on women especially in the context of HIV/AIDS epidemics. Current models for health planning do not take these implications into account and as a result the growing pressures on women and on their own health may remain largely invisible (Elson & Evers 1998).

Conclusion and research agenda

This brief review has shown that there is a dearth of evidence regarding the outcomes of the major reforms sweeping through health care systems in low- and middle-income countries. One size will not fit all and these policies need to be carefully shaped to meet local and national needs. But this cannot be achieved without a more rigorous and extensive knowledge base. Hence both quantitative and qualitative studies are needed to measure the impact of these policies as they are manifested in different settings. As we have seen, this research will need to recognize gender as a key variable if it is to provide an appropriate foundation of knowledge for effective and equitable health care systems (Ostlin, George & Sen 2002; Petchesky 2003).

Listed below are some of the most important gender-related issues requiring investigation in health care systems undergoing change:

- development of more accurate, inclusive and participatory methods

for measuring health care needs of women and men as a basis for health sector reform
- creation of more gender-sensitive indicators for monitoring and evaluating the impact of health sector reform across a range of services
- collection and dissemination of gender-disaggregated data at all stages of health sector reform
- more qualitative investigation of male and female experiences of health sector reform
- assessment of gendered impact of different health sector reform funding strategies on women and men and on household spending
- analysis of the impact of decentralization, integration of services and SWAPs on the quality and gender sensitivity of reproductive and other care
- development of time-use studies to investigate the impact of health sector reform on women's household work
- assessment of introduction of user fees and insurance schemes on access of males and females to health care
- investigation of gender differences in access to decision making about health sector reform among both users and workers
- investigation of the impact of health sector reform on the gendered division of labour in the health care workforce
- evaluation of different methods for promoting more female participation in planning of health sector reform
- greater clarification of the implications for health sector reform of links between gender and other determinants of health such as age, poverty and ethnicity
- development of new methods for assessing the impact of health sector reform on male and female sexual and reproductive health and beyond.

Workshop on gender, health and health sector reform at Forum 7

A workshop on gender, health and health sector reform at Forum 7 was attended by around thirty invited participants.* Yogan Pillay from the South African Department of Health was a discussant and responded to the papers from the perspective of a policy maker. Brief summaries of the four presentations are given here and longer versions are available at www.globalforumhealth.org. The first paper by Hilary Standing raises some of the more general issues relating to gender and health sector reform while the others examine related developments in specific settings; Gustavo Nigenda describes the initiative 'Improving the links between health sector reform and reproductive health services in Latin America and the Caribbean' funded by the Rockefeller Foundation; Priya Nanda outlines a project on reproductive rights carried out in India and Tanzania for the Center for Health and Gender Equity; and Rounaq Jahan analyses gender issues in health sector reforms in Bangladesh based on a study carried out by Columbia University and the International Women's Health Coalition.

- **Health sector reform: issues and challenges from a gender perspective**
  Hilary Standing, Senior Research Fellow, Institute of Development Studies, University of Sussex, UK

  Gender differences are reflected in health sector reform through a number of different routes: relations of distribution (who gets health care resources?), health care needs (how do these differ for women and men?), input into health care delivery (who does what?), decision making (who has the power to make what choices?) and social status (intersections with poverty and other aspects of stratification).

  The various strands of health sector reform have been complex and sometimes contradictory. In their current historical formulation they can be seen to have certain advantages from a gender perspective. The greater focus on outputs and service delivery is good for poor people in general and poor women in particular. There has been a clearer focus on making sure

* For details of this session and other specifically gender-related sessions at Forum 7, see the Annex.

that all voices are heard while advocates themselves are now more skilled and better informed. Initiatives such as women's budgets and the development of gender-sensitive indicators have made important contributions here.

However the negative effects are also very clear. In many settings the reforms have not worked for the poorest while inequalities continue to rise. Estrangement is often evident between the discourses of rights and the technical/managerial approach often adopted by those with power. The focus is too frequently on individual and household responsibility and away from collective public health objectives and there is little evidence of forward thinking about health and infrastructure needs.

Under these circumstances the main challenges can be summarized as follows. There need to be national-level commitments to gender equity in the heath sector and elsewhere. The informal economy needs to be properly understood and integrated into the planning process. New approaches need to be properly evaluated and real spaces created for informed dialogue and advocacy.

- **Transforming research results into valuable information: Latin American initiative to assess the links between health sector reform and reproductive health programmes**
  Gustavo Nigenda, Director, Centre for Economic and Social Analysis in Health, FUNSALUD, Mexico

  Health sector reform initiatives are widespread in Latin America and the Caribbean but research into their effectiveness has been scarce. In response to this situation the Rockefeller Foundation funded an initiative in five countries in the region. The aim was to focus mainly on the impact of health sector reform on reproductive health and to produce an evidence base for policy makers. The paper presents findings from Colombia, Peru and Uruguay.

  Two studies in Colombia examined barriers to sexual and reproductive health services for women. The Colombian health sector reform process set up a large health insurance system totally funded by the state but around 35% of the population still have to rely on public services. Though the

insurance system did remove some monetary barriers for women there are still many social cultural and geographical barriers. For those women not covered by insurance the obstacles to good care still remain very great.

In Peru an initiative to promote community participation in the decision-making process of primary care led to the creation of CLAS (Local Centres for Health Administration). This led to improvements in sexual and reproductive health services for adolescents and women though much work remains to be done. In Bolivia there has been a long history of training indigenous populations in reproductive health issues but this did not necessarily lead to change. In order to empower women more effectively they were also offered opportunities for income generation. The study showed that this enabled them to learn more actively and to put what they had learned into practice. Finally in the conservative context of Uruguay the paper describes how health sector reform improved sexual and reproductive health services.

The overall conclusion of the paper is that in this region health sector reform has been associated with innovations in service delivery especially for women. However major improvements are still needed to guarantee sensitive and high quality care for the whole population.

- **Studies on the implications of health sector reforms for reproductive health in India and Tanzania**
  Priya Nanda, Senior Program Associate, Center for Health and Gender Equity, USA

  Reforms in the health sector pose both opportunities and challenges in providing comprehensive health services for women. There is currently considerable debate on this issue but very little practical information exists. This paper presents findings from a study comparing two sites in India and one in Tanzania.

  The first Indian site in Tamil Nadu was one where there had been little health sector reform and the researchers examined revisions of the previous National Reproductive and Child Health Programme. In Kerala the level of reform was assessed as moderate and researchers focused on the implications of women's participation in political decentralization for

gender equity. Finally in the high reform setting of Tanzania the main focus of attention was the experiences of health workers themselves concerning decentralization while female users were asked about their perception of cost sharing and their experiences with user fees. The methods used in all three studies were in-depth interviews with women about what they saw as their gender-related vulnerabilities, their sexual and reproductive health problems and their experiences of care. Semi-structured interviews were also carried out with providers at different levels.

In all three sites it was evident that there had been little preparation for the reforms. And there was a lack of trust between providers and the district and village councils. User fees were not helping women and exemptions systems were not working well. The main vulnerabilities for women still seemed to be their lack of decision-making power, economic constraints and their burden of chronic reproductive and other morbidity.

- **Where does gender fit in the politics of health reforms?**
  Rounaq Jahan, Senior Researcher, Columbia University, USA

  States and international agencies promoting health sector reform often undertake economic or technical feasibility studies but rarely examine the political dimensions of change. This study was an attempt to fill this gap through looking at the experiences of one country. Bangladesh adopted its first Health and Population Sector Strategy (HPSS) in 1996 and a five-year Health and Population Sector Programme (HPSP) in 1998. This paper unpacks one aspect of the politics of these reforms by identifying and analysing the strategies used by women's health and rights advocates to move gender higher up the agenda. The research was based on documents, interviews with key informants, consultations with community-based groups and the author's own notes as a member of the World Bank team negotiating the reforms.

  HPSS/HPSP followed a familiar model in introducing SWAPs, integration of health and family planning services, community participation, decentralization and public-private/NGO partnerships. Following the IPCD approach, gender issues were mainstreamed in the design of the programmes with an Essential Services Package for reproductive health delivered through the primary heath care system. However a small group of

advocates primarily located in international donor agencies called for attention to be paid not just to reproductive health but also to gender equity. This they achieved through addressing players, power, position and perception.

They worked hard to get a critical mass of players to advocate and support the gender equity agenda. This involved the negotiation of key roles for existing advocates in the political process, identifying supporters among new and established players and involving new players in the actual design of HPSS/HPSP. In order to redistribute power in the direction of the advocates they built strategic alliances with existing participants and then empowered new players, giving funds for community and stakeholder participation for example. In order to reshape positions and perceptions among the various players they traded priorities with strong players and worked to create a common vision and perception. In particular they worked to change the belief that their agenda was focused only on women's health and supply-side solutions. They presented gender issues in technical terms and linked gender concerns with national equity concerns.

The overall conclusion of the paper was that policy designs can be influenced even by a small group of advocates if the politics are taken seriously. But this will only be achieved if effective communications strategies are used and strong civil society organizations are involved. Very importantly, the paper also highlights the political difficulties of moving from planning to implementation and ensuring that the goals are put into practice.

Bibliography

Antarsh L et al (2000) *Health sector reform and reproductive health in transition: meeting the challenge in Tanzania, Bangladesh and Columbia* New York: AVSC International (now Engender Health)

Araujo M (1998) The role of local authorities in implementing health care with the gender perspective: the case of the Women's Total Health Care program in Sao Paulo, Brazil in *Mainstreaming the gender perspective into the health sector* UN CSW Expert Group meeting on Women and Health 28 Sept-2 October 1998 Tunis New York: UNDAW

Askew I & Maggwa B (2002) Integration of STI prevention and management, family planning and antenatal care in sub-Saharan Africa: what more do we need to know? *International Family Planning Perspectives* 28 (2) pp 77-86

Berman P (ed) (1995) *Health sector reform in developing countries* Boston MA: Harvard University Press

Blas E & Hearst N (2001) Learning from experience: research on health sector reform in the developing world *Health Policy and Planning* 16 supplement 2 pp 1-4.

Blas E & Hearst N (2002) Health sector reform and equity: learning from evidence? *Health Policy and Planning* 17 supplement pp 1-4.

Cassells A (1995) Health sector reform: key issues in less developed countries *Journal of International Development* 7, 3 pp 329-347

Dehne K, Snow R, O'Reilly K (2000) Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits? *Bulletin of the World Health Organization* http://www.who.int/bulletin/pdf/2000/issue5/bu0563.pdf

DeJong J (2000) The role and limitations of the Cairo International Conference on Population and Development *Social Science and Medicine* 51: pp 941-53

Elson D & Evers B (1998) *Sector programme support: the health sector, a gender aware analysis* Manchester: University of Manchester, Genecon Unit

Ekwempu C et al (1990) Structural adjustment and health in Africa *Lancet* 336 pp 56-57

Evers B & Juarez M (2002) Understanding the links: Globalization, health sector reform, gender and reproductive health in D Meacham (Ed) *Globalization, health sector reform, gender and reproductive health* New York: Ford Foundation

Fox-Rushby J (2002) *Disability Adjusted Life Years (DALYs) for decision making? An overview of the literature* London: Office of Health Economics

Gomez Gomez E (2002) Gender equity in health sector reform policies in Latin America and the Caribbean *Revista Pan Americana de Salud Publica* 11 (5) pp 435-438

Hanson K (2002) Measuring up: gender, burden of disease and priority setting in G Sen, A George and P Ostlin (eds) *Engendering international health: the challenge of equity* Cambridge: MIT Press

Hardee K & Smith J (2000) *Implementing reproductive health services in an era of health sector reform* Washington DC: The Futures Group Occasional Papers no 4

Hussein A & Mujinja P (1997) Impact of user charges on government health facilities in Tanzania *East African Medical Journal* 74 (12) 751-57

Kassels A & Jankovsky K (1998) Better health in developing countries: are sector wide approaches the way of the future*? Lancet* 352 pp 1777-79

Krasovec K & Shaw R (2000) *Reproductive health and health sector reform: linking outcomes to action* Washington DC: World Bank Institute Working Papers

Kutzin J (1995) *Experience with organizational and financing reform of the health sector* Current concerns SHS paper no 8 (SHS/CC/94.3) Geneva: WHO

Lakshminarayanan R (2003a) *Gender and health sector reform: an annotated bibliography* New York: International Women's Health Coalition

Lakshminarayanan R (2003b) Decentralisation and its implications for reproductive health: the Philippines experience *Reproductive Health Matters* 11 (21) pp 96-107

Langer A et al (2000) Health sector reform and reproductive health in Latin America and the Caribbean: strengthening the links *Bulletin of the World Health Organization* 78 (5) pp 667-676

Liverpool School of Tropical Medicine (2000) *Gender inequalities and health sector reform* Policy briefings for health sector reform no 2 Liverpool: LSTM

Lubben M et al (2002) Reproductive health and health sector reform in developing countries: establishing a framework for dialogue *Bulletin of the World Health Organization* 80 (8) http://www.who.int/bulletin/pdf/2002/bul-8-E-2002/bu1060.pdf

Lush L et al (1999) Integrating reproductive health: myth and ideology *Bulletin of World Health Organization* 77 (9) pp 771-777 http://www.who.int/bulletin/pdf/issue9/bu0042.pdf

Mayhew S (2000) Integration of STI services into FP/MCH services: health services and social contexts in rural Ghana *Reproductive Health Matters* 8 pp 112-124

Meachem D (ed) (2002) *Globalization, health sector reform, gender and reproductive health* New York: Ford Foundation

Moses S et al (1992) Impact of user fees on attendance at a referral centre for sexually transmitted diseases in Kenya *Lancet* 340 pp 463-466

Murray C & Lopez A (eds) (1998) *Health dimensions of sex and reproduction: the global burden of sexually transmitted diseases, HIV, maternal conditions, perinatal disorders and congenital anomalies* Cambridge MA: Harvard University Press

Nanda P (2000) *Health sector reforms in Zambia: implications for reproductive health and rights* Working paper, Tacoma Park, Maryland Center for Health and Gender Equity

Nanda P (2002) Gender dimensions of user fees: implications for women's utilisation of health care *Reproductive Health Matters* 10 (20) pp 127-134

Onyang C (2001) *Gender and equity in health sector reform: a review of the literature* Washington DC: PAHO/WHO

Ostlin P, George A, Sen G (2002) Engendering health equity: a review of research and policy in G Sen, A George and P Ostlin (eds) *Engendering international health: the challenge of equity* Cambridge: MIT Press

Petchesky R (2003*) Global prescriptions: gendering health and human rights in a contemporary setting* London: Zed Books

Reproductive Health Matters (2002) (special issue on health sector reforms: implications for sexual and reproductive health services) RHM vol 10 no 2

Standing H (1997) Gender and equity in health sector reform programmes: a review *Health Policy and Planning* 12 (1)

Standing H (1998*) Gender aware human resource planning and management in the context of support to health sector reform* (with Sally Baden, G Bloom and R Masika) Bridge IDS, University of Sussex

Standing H (2002) Framework for understanding health sector reform in G Sen, A George and P Ostlin (eds) *Engendering international health: the challenge of equity* Cambridge: MIT Press

Women's Environment and Development Organisation (1998) *Risks, rights*

and reforms: a fifty country survey assessing government actions five years after the International Conference on Population and Development New York: WEDO

Waddington C & Enyimayew K (1990) A price to pay part 2 : the impact of user charges in the volta region of Ghana *International Journal of Health Policy and Management* 5 (4) 281-312

Working Group on Reproductive Health and Family Planning (1999) *Report of meeting on the implications of health sector reform on reproductive health and rights Dec 1998* Washington DC: Center for Health and Gender Equity and Population Council

World Bank (1993) *World Development Report 1993* Washington DC

ANNEX

Forum 7, Geneva. 2-5 December 2003
Sessions with a specific gender focus*

WORKSHOP

Gender, health and health sector reform

Chair:

- Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

With:

- Hilary Standing, Research Fellow, Health and Social Changes Programme, Institute of Development Studies, University of Sussex, United Kingdom
  - Health sector reform - issues and challenges from a gender perspective
- Gustavo Nigenda Lopez, Director, Centre for Social and Economic Analysis in Health, Mexican Health Foundation, Mexico
  - Transforming research results into valuable information: Latin American initiative to assess the links between health sector reform and sexual and reproductive health programmes
- Rounaq Jahan, Senior Research Scholar, School of International and Public Affairs, Southern Asian Institute, Colombia University, USA
  - Where does gender fit in the politics of health sector reforms?

Discussant:

- Yogan Pillay, Chief Director, Strategic Planning, National Department of Health, South Africa

* Presenters are listed here with their title and affiliation as of Forum 7.

PLENARY SESSION

Gender, health and global restructuring

Chair:

- Mahmoud F. Fathalla, Chairman, WHO Advisory Committee on Health Research, World Health Organization, Geneva

With:

- Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom
  - Researching the impact of globalization on gender health: an overview
- Helena Nygren-Krug, Health and Human Rights Adviser, Strategy Unit, Director General's Office, World Health Organization, Geneva
  - Global restructuring, gender and human rights
- Vikram Patel, Senior Lecturer, London School of Hygiene and Tropical Medicine, United Kingdom
  - Global restructuring, gender and mental health

SESSIONS IN PARALLEL

1) Poverty, gender and health research

Chair:

- Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom

With:

- Mubashar Sheikh, Regional Adviser, Community-Based Initiatives, World Health Organization/EMRO, Cairo
  - Basic Development Needs: a strategy to improve gender imbalance and reduce poverty
- Salma Galal, Technical Officer, Gender and Women's Health, World Health Organization, Geneva
  - Basic Development Needs programmes in a semi-rural area of Cairo, Egypt

- David Rush, Professor Emeritus, Nutrition, Community Health and Pediatrics, Tufts University, USA
  - Maternal Nutrition and perinatal survival
- Anna Thorson, Researcher, Public Health Services, International Health, Karolinska Institutet, Sweden
  - Equity and equality: case detection of tuberculosis in Vietnam

2) Gender, health research and displaced populations

Chair:

- Andrew Y. Kitua, Director General, National Institute for Medical Research, Tanzania

With:

- Derek Ellerman, Co-executive Director, Polaris Project, USA
  - Human trafficking
- Danielle Grondin, Director, International Organization for Migration, Geneva
  - Identifying health problems of refugees
- Jens Modvig, Secretary General, International Rehabilitation Council for Torture Victims, Denmark
  - A report on the work of the International Rehabilitation Council for Torture Victims

3) Gender, health research and ageing

Chair:

- Martine Berger, Special Adviser, Public Health, Multilateral Affairs Section, Swiss Agency for Development and Cooperation, Switzerland

With:

- Lesley Doyal, Professor, School for Policy Studies, University of Bristol, United Kingdom
  - Gender, health research and ageing: global research priorities
- Alexandre Kalache, Coordinator, Ageing and Life Course, World Health Organization, Geneva
  - Gender and ageing: demographic and economic dimensions

- Sandhi Maria Barreto, Associate Professor of Epidemiology, Social and Preventive Medicine, Faculty of Medicine, Federal University of Minas Gerais, Brazil
  - Gender patterns of health care use in older age

Lesley Doyal is Professor of Health and Social Care at the School for Policy Studies, University of Bristol. She has published widely in the area of gender, health and health care and has worked as a consultant for a range of organizations including the United Nations, WHO, the Commonwealth Secretariat and the Global Forum for Health Research.

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