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Opinion

Gender equity and health indicators in the context of health reforms

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The question of how to monitor the gender impact of health sector reforms (HSR) was first raised in the 1990s in the context of the wave of reforms in low and middle income countries, some of which were driven by multilateral and bilateral donors. Reforms focused particularly on the organisational reform of national machineries of planning and service delivery such as ministries of health and public sector human resources, on sector financing mechanisms, on different models of decentralisation that might deliver greater local "voice" and on contracting of private providers. These reforms had strong components of both cost control in the context of structural adjustment policies, and of improving the management and delivery of services in a context of poor public sector performance.

Inserting gender and equity considerations into the monitoring and evaluation of HSR has proved challenging. The pioneering work of the La Trobe Consortium for the Kobe Women and Health Programme on gender sensitive indicators within a comprehensive Health Information Framework has made visible the reasons for this. First, indicators in the health sector are overwhelmingly biomedical and whole population based. As their analysis notes, indicators for tracking system level change are the least developed or prevalent. There are whole areas of monitoring where sex or any other equity related data disaggregation is lacking. Second, finding easily trackable gender sensitive indicators that can proxy for the impact of broader organisational changes in the health sector has proved a difficult task. Third, there is no obvious agreement on what the priorities are for gender equity indicators in health in a context of HSR. What are the best proxies for gender equitable health outcomes – access to services, financial allocations, quality of care, greater voice and empowerment for users?

Health sector reform is also a moving target. The prescriptive, blueprint approach which characterised the 1990s (often taken without modification from the experience of the OECD countries or the USA) failed in many cases to produce positive improvements in access to, and utilisation and quality of services. It was difficult to find the link between the "upstream" approach of HSR focused on higher level organisational change and the "downstream" improvements they were supposed to effect. Indicators in themselves cannot fill this gap. One can perhaps now detect a greater pluralism in approaches to reforms, together with a stronger emphasis in reform programmes on outcomes rather than structural reforms. Indicators need therefore to reflect these.

What are some of the lessons and continuing challenges for monitoring HSR impact? In many ways, these are not specific to HSR. Effective monitoring within the kind of Health Information Framework already proposed would also capture HSR impacts. One of the biggest challenges at programme level is actual capacity to undertake monitoring of any kind. Health Management Information Systems in many poor countries are in bad shape. A demand to add additional indicators or to initiate sex disaggregation can present enormous practical problems. While gender equity monitoring should be seen as an essential component of good practice health systems monitoring, there is an argument for interim measures, such as using existing sentinel sites and encouraging or enhancing the capacity of other bodies - research institutions, civil society organisations – to monitor specific aspects of HSR from a gender perspective. As gender equity will always carry a political charge, the engagement of wider stakeholders in the monitoring process makes it more likely that information will be made available and used.

What have been some of the successes in monitoring the gender impacts of HSR? Capacity has developed through several routes. First, there are partnership approaches spanning international organizations, governments and other stakeholders.

The most serious efforts have undoubtedly been in Latin America, notably as a result of the work of the Pan-American Health Organization (PAHO) through the outreach of its Women, Health and Development Program to both government and civil society partners. This has resulted in major operational research to develop and embed gender monitoring frameworks for HSR across the region and official guidance to countries.

Second, there are sector programme specific examples of improved monitoring capacity. In Bangladesh, the policy priority of improving the health of poor women and girls adopted by the Government in its health sector reform programme resulted in a much higher profile for gender issues and improvements in monitoring. It greatly increased the extent of sex disaggregated data collected in the HMIS. Under the last Health and Population Sector Programme, the Human Resources Department developed a management information system which enabled them to track the gender dimensions of the health workforce in a context of concern about gender based employment inequalities.

Third, there has been the development of informed advocacy spearheaded by civil society and research organizations. The HealthWatch Trust in India is an informal network of health activists and researchers which has been monitoring reproductive health reforms over the last decade and engaging in dialogue with key players in government. Useful tools and frameworks have developed which can support more effective monitoring. Examples include the gender budgets initiative which tracks expenditures in a gender diaggregated way. Started by a group of academics and activists in South Africa, it has now spread internationally. The health equity gauge had similar origins and is now an established methodology for measuring different dimensions of equity.

Lastly, work in formerly invisible areas, such as gender based violence, provides new possibilities for developing gender and health equity indicators that can proxy for the kinds of wider changes that should be expected from effective HSR that places those most in need at the centre of the process.

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