Pan American Health Organization Regional Office of the World Health Organization

EVALUATING THE IMPACT OF HEALTH REFORMS ON GENDER EQUITY – A PAHO GUIDE

Introduction

This guide has been produced by the Pan American Health Organization (PAHO) to aid in monitoring and evaluating the impact of health reform processes on gender equity in the region.

Gender, health and health sector reform

Health systems do not necessarily treat men and women equally according to their needs. This has been a major finding of research into gender and health in the last few years. Inequalities have been noted in access to services, in treatment received, in share of expenditure, in human resource policies and in voice and representation. Gender equity in health has thus become a key area of concern. There are two important landmarks in this. The first was the International Conference on Population and Development (ICPD) in Cairo in 1994. This produced a major shift in thinking about the nature of family planning and maternal and child health programmes. Instead of population targets, the emphasis moved towards comprehensive, client friendly programmes, sensitive to the needs of women and men. Instead of vertical programmes which fragment health needs, ICPD inaugurated a move towards integrated reproductive health programmes covering the lifespan needs of women and men.

Allied to this was a strong focus on women's rights and empowerment and the need for the health sector to play a role in attaining wider gender equity goals. This challenge was reinforced in the international platform of action from the Beijing women's conference in 1995, where women's health was also linked to the broader human rights agenda.

International development agencies are increasingly recognising the importance of gender equity in health in affecting development outcomes. Recently, the World Bank noted that in the past, 'women's health' issues have been relegated to MCH, and family planning projects. They have called for mainstreaming of gender across all sectors and in health sector reform programmes. In PAHO, gender equity in health and health as a human right are mandated in all their programmes and projects.

Health reforms are taking place across the region. They are responding to a range of factors. These include political reforms, such as decentralisation, economic reforms, such as the need to improve efficiency and coverage, and ideological reforms, such as

moves to "roll back the state" and make greater use of the private sector. Reforms can thus affect every aspect of the health system – financing, human resources, management, population health planning and service delivery. There is now evidence that health reforms affect women differently from men. It is vital, therefore, that reforms be monitored with their gender equity implications in mind. This guide is a contribution to that effort.

Conceptual framework

The concept of gender

The term gender refers to the ways in which the relations between the sexes are organised in society, and their associated roles. This is to distinguish it from the term sex, which refers simply to the biological differences between women and men. There are two main ways in which we can make the link between gender and health. The first is through a women's health needs approach. This approach highlights the specific health needs of women and girls through the life cycle. It includes their reproductive health needs.

The second is through looking at the ways in which the social relations between women and men produce inequalities in health outcomes and in access to and utilisation of health services. This is due to unequal control over economic resources, as well as social and cultural factors. This approach considers the broader context of power relations within society and the way these affect health through gender inequality. In practice, there is much overlap between the two: women's health needs, and whether they are met, are closely related to gender relations. The link between gender and health also enables men's health and men's responsibilities for health to be understood and addressed.

Gender equity in health

Gender equity can be conceptualised in two main ways: first, that either women or men do not receive less or inferior treatment by virtue of their sex. An example of this is that in the developing world, rates of TB are similar in both women and men but data on attendance at health facilities from a number of countries show that women are much less likely to go for treatment. This can lead to the erroneous assumption that TB rates are lower among women.

Second, gender equity also entails that health needs which are specific to each gender receive appropriate resources. In particular, women and girls have reproductive health needs which carry additional resource implications. They may also have other special needs, for instance relating to their greater vulnerability to gender violence.

Gender equity in health as a human right

Rights approaches represent a difference in emphasis between seeing health primarily as meeting different needs, to seeing it as an entitlement of citzenship.

A rights based understanding of equity begins with the 1945 UN Charter of.Human Rights which guarantees equity between the sexes. In accordance with this, a number of these conventions impose obligations on signatory governments to promote women's health and remove barriers to its achievement. For instance, 130 states are

parties to the Convention on the Elimination of all Forms of Discrimination against Women (the Women's Convention) of 1979. This explicitly includes rights to health care and family planning.

The Women's Convention goes beyond the earlier principle of non-discrimination between the sexes to focus on the distinctive treatment of discrimination *against* women in specific arenas. In particular, it focuses on the so-called "second generation" of rights, which are economic, social and cultural. It is in this second generation that health care is conceptualised as a human right. For instance, the "right to life" principle includes the right not to die in childbirth. A rights based approach is also integral to the health resolutions adopted at the Fourth World Conference on Women, held in Beijing in 1995.

Important features of an emphasis on rights are:

1. The health disadvantages which women experience are injustices which violate the rights of an individual or group.
2. The concept of rights to health goes beyond the provision of services to a vision of health which includes empowerment and participation.
3. State signatories have an obligation to take positive steps in accordance with their judgement of the most pressing problems, although signing up is voluntary.

Why is it important to consider gender in the context of health reforms?

Most low and middle income countries are undertaking similar kinds of reforms, and all aspects of health reforms have gender implications.

Major Elements of Reforms:

- Improving health sector management systems
- Public sector reform
- Priority setting and cost effectiveness
- Reform of financing mechanisms, cost containment
- Basic packages and insurances
- Decentralization
- Working with the private sector (public-private partnerships)

While health reforms can undermine gender and health equity, it is useful to ask how each main element of reform can contribute to supporting it.

- *How might improving health sector management systems support gender and health objectives?*

Improving health sector management systems provides opportunities to address issues of quality of care in service delivery. Women often experience poor treatment in health facilities, particularly in the public sector. Both women and men also need access to services where health providers can respond appropriately to their needs. In some contexts (e.g. areas of reproductive health), this may mean ensuring the availability of same sex providers.

Human resources restructuring can also be an opportunity to address the career development, terms and conditions of female health workers, who provide much of the first line service delivery.

- *How might priority setting support gender and health objectives?*

Priority setting and monitoring tools can be made more sensitive to equity issues by developing greater public participation with user and provider stakeholders and ensuring that women's voices are adequately represented. This can be done using a range of methods, such as stakeholder workshops and participatory appraisal

- *How can reform of financing mechanisms support gender and health objectives?*

Developing women's budgets and mechanisms for improving accountability of health and social sector expenditure can empower citizen's groups to press for improved equity.

How can basic packages and insurances support gender and health objectives
Micro-credit, revolving saving schemes and insurances where women can build up their own "health credits" can be developed. Basic packages can be monitored to ensure that they include essential women's health interventions, particularly for reproductive health

- *How can working with the private sector support gender and health objectives?*

Contracting out of services to the non-governmental sector gives governments leeway to define standards (e.g. for quality of service) and to develop a framework of incentives to address the specific health needs of women and girls and of groups with particular health risks.

- *How can decentralization support gender and health equity objectives?*

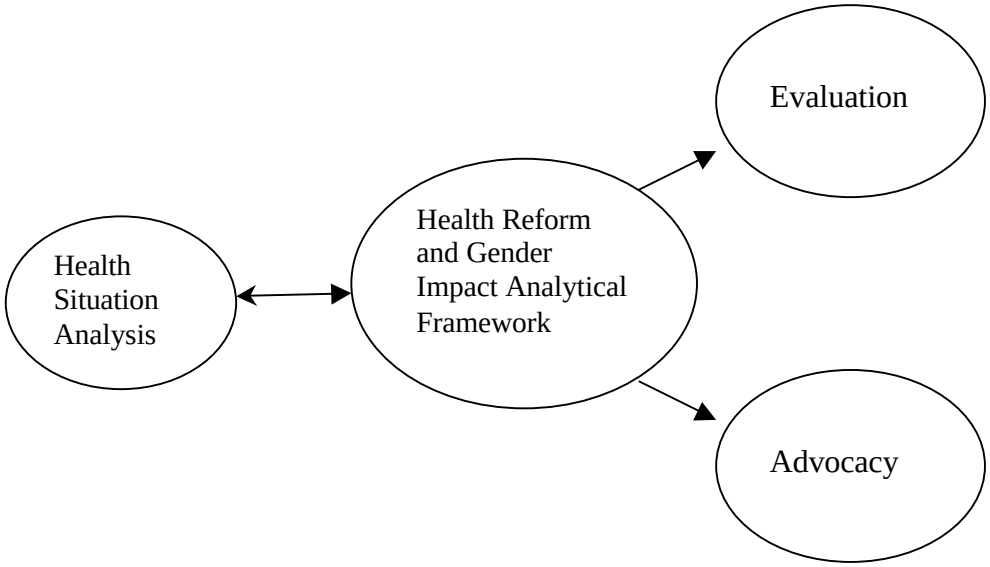
If the process of decentralization involves local stakeholders, including women's groups, in consultation and design, gender equity can become part of the agenda. This requires a concerted effort to ensure that stakeholder participation includes the voices of the less powerful, both women and the poorest households. It may mean designing mechanisms specifically to provide for their representation on local bodies.

Aims and Audience
The aim of this guide is to provide a practical tool for guiding deliberations and developing evaluations of the impact of health reforms on gender equity. It is based on several sources and approaches to evaluating equity, including gender equity. It reflects the as yet limited experience in the practical monitoring of gender and health equity. It is therefore meant as guidance only, and we welcome feedback, comments on its usefulness and suggestions for modifications and additions.

The guide has been written for two main audiences. The first is health planners and senior managers in government departments who are developing systems for monitoring reform impacts on specific population groups. The second is advocacy groups, and research institutions, particularly those concerned with women's health and with the equity effects of health reforms in their countries.

It can thus be used both an evaluation and an advocacy tool. Groups can use it (1) to assist in deciding on key indicators for measuring the impact of reforms, (2) in developing their monitoring and evaluation systems, or (3) in setting aims for advocacy work with politicians and official stakeholders in the health sector.

In order to use the guide for evaluation or advocacy, a health situation analysis will be needed which is sensitive to gender issues. In some countries, this may already be available, at least in part. In others, it will be necessary to carry this out as part of the process of monitoring and evaluating gender impacts of reforms.



Origins of the analytical framework

The framework draws on and amalgamates a number of different sources. The two main ones are Standing (1997,1999) and Daniels et.al. (ref). Standing's work specifically addresses the gender impacts of different elements of health sector reform as it came to be practised in the 1990s by donors and by many national governments. She raises a series of issues and questions for each of these elements. Daniels has developed the concept of benchmarking as a policy tool for assessing the impact of health reforms in developing countries. While Standing uses an equity framework for raising issues about health reforms, Daniels' benchmarks are based on the concept of "fairness" as the basic principle for assessing the reform process. Benchmarks cover a range of important dimensions of fairness in health care, such as financing mechanisms, promotion of needs based coverage, reductions in barriers to access and public accountability. Fairness was chosen rather than equity as it was considered to be a broader term encompassing access, outcomes, efficiency and accountability. We have used both terms here, as equity is the more commonly used term in the gender and health literature.

How can the framework be used?

We recognise that the countries in the region vary very greatly in their economic development and in the types and coverage of their health systems. Therefore not all components of the framework, or all issues raised will be equally applicable to every country or locality within the country. Nor will the suggested priority issues under each component be necessarily the most appropriate for every context This is not intended as a prescriptive guide. Users should come to their own decisions about the value and applicability of the different parts of the framework. Alternatively, they may choose to add others.

Users must also decide the best way to operationalise the framework. For instance decisions need to be taken on whether to take on the whole framework at once, or to select some aspects as priorities, leaving others for later. There is also the question of how to measure progress over time. The issues in the framework can be fairly easily turned into indicators for the purposes of evaluation. We have provided a list of key areas where it may make sense to assess reforms against gender equity criteria.

Here is a possible process for introducing the framework:

1. Initiating group goes through framework and makes any changes or additions that they think are needed.
2. Process for influencing policy is agreed.
3. Group organises discussions/meetings with other interested stakeholders to refine the framework in the light of local realities.
4. Implementing team is established, decides on operational procedures and begins process of developing situational analysis.
5. Team produces preliminary findings and feeds back to key stakeholders.
6. Analysis is refined and disseminated to policy makers, politicians, media etc.

ANALYTICAL FRAMEWORK FOR ASSESSING THE IMPACT OF HEALTH REFORMS ON GENDER

The Categories

For each component of the framework, three categories are identified in three columns. The first column identifies a key issue or area of concern which contributes to the overall component. The second column lists some key questions to guide the analysis. Analysing, monitoring and evaluating impact will require the collection of information, together with appropriate baseline data from which to measure change. The third column is therefore about data collection. It is divided into two areas. The first set of bullet points gives guidance on main sources where information may be found. Note that these mean existing sources only - this is not a guide to methods of data collection. The second set of bullet points suggests relevant indicators or situational analysis data needs which would help to answer the questions in the second column.

1. Intersectoral public health

The health of a population and the distribution of health status within it is a key measure of social justice. This component is concerned with how well the wider determinants of health are integrated into health reform processes. These areas are generally dealt with in other sectoral policies and programmes. But people's health and wellbeing are dependent on this wider range of public policies and actions. This component looks at the extent to which there is intersectoral engagement in improving population health. Generally, it asks what actions are being taken to encourage intersectoral collaboration. Specifically, it considers efforts in key areas which determine or influence health. In some areas, issues have been selectively chosen. Others may be more relevant or appropriate, depending on the country.

Each of the following areas has important gender implications:

- ✓ Nutrition
- ✓ Environment
- ✓ Water and Sanitation
- ✓ Education
- ✓ Social security
- ✓ Employment
- ✓ Public and personal safety
- ✓ Law

Intersectoral public health

Issues	***Questions***	***Data sources and needs***
Nutrition	*Is there a national nutrition policy?* *Are there data and action plans for improving the nutritional status of*	• National and local authorities. • Nutrition surveys ❑ Extent of major nutritional deficiencies

	women and girls?	among reproductive age women and adolescent girls by socio-economic/ethnic status
Environment	*Is there substantial use of traditional biomass fuels in the household which cause major health problems for women and children?* *Are plans in place to reduce reliance on these?*	• National environment strategy • Air pollution surveys • Local studies ❑ Extent and nature of use by socio-economic/ ethnic status ❑ Interventions tried on e.g. solar cooking
Water and Sanitation	*What percentage of households lack clean water and adequate sanitary facilities?* *What progress is being made to reduce this?*	• National water and sanitation policies • Government statistics ❑ Extent of water borne disease by socio-economic/ethnic status
Education	*What is the proportion of girls completing primary and secondary education?* *What policies are in place to prevent drop out, e.g. through early pregnancy?*	• Government statistics • National policies on gender and education • Independent evaluations
Social security	*What is the coverage of the population in terms of statutory social security benefits?* *What plans are in place to expand coverage to more disadvantaged groups, such as informal sector women workers?* *What NGO programmes address this?*	• Government statistics • Surveys – official and independent ❑ Extent of formal coverage by socio-economic/ethnic status ❑ Extent and activities of informal sector workforce
Employment	*What health and safety legislation is in place and which groups of workers does it cover?* *What attention is being paid to occupational health hazards suffered by informal sector women workers?*	• National and local authority legislation • Occupational surveys • Trade unions and advocacy groups ❑ Numbers of officially reported industrial accidents ❑ Key risk activities

Public and personal safety	*What initiatives are there on reducing crimes which particularly affect women, such as rape and domestic violence, and dealing with their consequences?* *e.g. improving police response, providing safe houses*	• National and local authorities • Women's groups and NGOs ❑ Trends in incidence by socio-economic/ethnic status ❑ "Good practice" initiatives
Law	*Do national or customary laws have adverse impacts on women?* *e.g. abortion laws, property rights* *What progress is being made to change them?*	• National legal authorities • Religious affairs authorities • Women's advocacy groups ❑ Study of court cases and outcomes
Transport	*Does transport planning take account of women's specific travel needs and constraints?* *Has a gender audit of transport taken place?*	• National and local transport authorities • Independent surveys ❑ Needs assessment of women's transport use
Extent of effective intersectoral collaboration	*Are there mechanisms for developing inter-sectoral efforts on health improvements?* *Has decentralisation affected intersectoral co-operation? How?* *Are women less or more able to contribute to setting local agendas?*	• Interviews with national and local functionaries, advocacy groups and other key stakeholders ❑ Considered views of key stakeholders

2. Health care entitlement and exclusion

Equity of access to services requires that financial barriers are minimized through a combination of publicly financed health services and insurance schemes. This component is concerned with the way gender acts as a basis of categorical exclusion from entitlements. This is because it is embedded in key determinants of entitlement, such as employment status. In many countries, a large part of the population is in the informal economy and has no access to formal schemes, including cover for maternity care or other reproductive health needs.

Women are particularly vulnerable to exclusion from formal health entitlements. In the region, large numbers work in casual employment, such as domestic service. Women are more likely to be in part time or seasonal employment. More than 50% of women in the economically active age groups are outside the paid labour force and

dependent on other household members for coverage of their health needs. This is of particular concern in contexts where there are high levels of marital instability. The design of entitlements, such as public, social and private insurance systems therefore has a major impact on women's access to health care.

Health care entitlement and exclusion

Issues	***Questions***	***Data sources and needs***
Access to health care entitlements	*What is the extent of health insurance and social security coverage in the population broken down by formal and informal sectors?* *What plans are there for reforming health and social security entitlements and have gender impacts been considered?*	• National data – ministries of health, finance, employment, social security • Policy statements
Relationship between employment status, gender, age and health entitlements	*What proportions of women in informal sector, casual or seasonal employment have access to health benefits?* *What proportion of women have access to cover as dependants of employees?* *What protections are in place for dependent women on divorce or death of husbands?* *Is maternity care provided regardless of a woman's employment status?* *What proportion of elderly women and men have access to health benefits?*	• National policies – ministries of health, finance, employment, social security • Field level research studies ▫ Extent of gaps in coverage

3. Institutional barriers to health facilities access

This component is concerned with the institutional (supply side) barriers which prevent or limit the extent of users seeking care. There are potentially many gender issues to be aware of and again, a country specific analysis will be needed. Here, two kinds of barriers: facilities level barriers such as geographical location and physical infrastructure, and provider level barriers, such as attitudes and availability of same sex providers. Note that these issues and questions are equally applicable to public and private sector provision of services.

Institutional barriers to health facilities access

Issues	Questions	Data sources and needs
Geographical distribution	*Is distance an obstacle for rural women in reaching health facilities?* *What changes are proposed to reduce this barrier?*	• Studies on health seeking behavour by independent researchers, NGOs etc ❑ Manageable distances for women by location
Transport availability	*What transport problems do women face in getting to facilities?* *What means of transport are available for pregnant women to reach delivery facilities?* *How will reforms mitigate these problems?*	• Studies on health seeking behavour by independent researchers, NGOs etc ❑ Patterns of transport use by women in reaching facilities
Opening times and hours	*Are these convenient or inconvenient for users, particularly women with children and household responsibilities?* *Will the reforms improve this?*	• Studies on health seeking behavour by independent researchers, NGOs etc • Client satisfaction surveys ❑ Typical opening patterns in public and private sectors
Supply of drugs	*Are there problems with drug supply at public facilities?* *What do users do?* *Will the reforms address this?*	• Studies on health seeking behavour by independent researchers, NGOs etc • Client satisfaction surveys ❑ Time and financial costs to female users of poor supply
Physical infrastructure	*What proportion of PHC facilities are in good, average or poor condition?* *Are there facilities for children?* *Are there toilets and private examination areas?* *Will the reforms improve these?*	• Official surveys of infrastructure • Client satisfaction surveys ❑ Regional and socio-economic differences in access to acceptable facilities
Referral systems	*Are referral mechanisms for obstetric emergencies*	• National/regional data on maternal mortality

	functioning properly? *What proportion of at risk women reach referral facilities in time/late/not at all?* *How are reforms tackling this?*	and morbidity • Surveys of referral functioning ❑ Extent of referral failure by region
Availability of RH services for men and encouragement of male involvement	*Are services provided for men by appropriately trained providers and publicised?* *Do the reforms address men's health RH needs?*	• Client satisfaction surveys • Health workers training curricula • NGOs working in area of male sexuality ❑ Inventory of provision by region
Availability of RH services for adolescents	*Are services provided for adolescents by appropriately trained providers and publicised?* *Do the reforms address adolescents' health needs?*	• Client satisfaction surveys • Health workers training curricula • NGOs working in area of adolescent sexuality ❑ Inventory of provision by region
Availability of preferred types of provider	*Are same sex providers available for women and men where they are desired for sensitive examinations?* *Do the reforms expand or narrow choice?*	• Studies on health seeking behavour by independent researchers, NGOs etc • Client satisfaction surveys ❑ Pattern of availability by socio-economic location
Attitudes of providers	*Are providers, sensitive to the needs particularly to the poor and women?* *Are there plans to reform provider training?*	• Studies on health seeking behavour by independent researchers, NGOs etc • Client satisfaction surveys ❑ Differences by socio-economic/ethnic status
Legal obligations of providers	*Are providers required to report women seeking or having had abortions?*	• National laws • Women's advocacy groups ❑ Extent to which this deters women from seeking treatment
Language	*Are indigenous peoples'*	• Policy documents on

	language and communication needs recognised in planning of services and health promotion material?	health promotion • Studies on health seeking behavour by independent researchers, NGOs etc • Extent to which language barriers discourage treatment seeking ❑ Availability of materials in minority languages

4. Cultural and social barriers to health facilities access

This component is concerned with barriers to access which come from the demand side. These involve the roles particularly of families and the wider society in limiting the access to health care of women and girls. Many studies report lower utilisation rates of health facilities, particularly by poor women and girls, as a result of household level discrimination. Access to and utilisation of health services by women and girls are influenced by cultural and ideological factors, such as embargoes on consulting male practitioners (or strong preferences for a female provider), lack of freedom to act without permission from husbands or senior kin and low valuation of the health needs of women and girls as compared to that of men and boys. Access may also be limited by time and money costs, problems of physical mobility and women's lack of decision making power.

Health reforms can address these issues in various ways, such as by improving the capacity of the system to offer the choice of a female provider and abolishing requirements for consent by other parties such as husbands.

Cultural and social barriers to health facilities access

Issues	**Questions**	**Data sources and needs**
Access to facilities	*Are women and girls restricted in their access to services by cultural factors such as the need to be accompanied, time factors due to household responsibilities, or lack of access to transport?* *Do the reforms address the access problems of women and girls?*	• Studies on health seeking behavour by independent researchers, NGOs etc • Sociology/gender studies ❑ Extent and causes of mobility problems by socio-economic/ethnic status
Access to resources	*Do women and girls have the same access as boys and men to household expenditure on health*	• Household expenditure surveys • Data on health facility utilisation by sex

	care? *Do the reforms address inequalities in utilisation of services?*	• Sociology/gender studies ❑ Differences in utilisation rates for non-sex specific conditions
Decision making autonomy	*Do women and adolescent girls have decision making autonomy for themselves and on behalf of others, e.g. ability to treat themselves and children without consulting family members, obtain contraception*	• Studies on health seeking behavour by independent researchers, NGOs etc • Sociology/gender studies ❑ Extent of barriers by age, socio-economic status/ ethnicity

5. Equitable financing

This component is concerned with the extent to which national and local health financing mechanisms promote or detract from greater gender equity. There are two dimensions to this. One is the extent to which the overall financing regime promotes fairness through reducing the degree of segmentation of access to benefits. The other is relative equity within different types of financing mechanisms.

HSR programmes have particularly involved developing new health financing and cost recovery options, e.g. user fees, community financing schemes, insurance and vouchers.
Broadening health financing options raises three main gender issues:

- Are women more disadvantaged by particular modes of payment (or are they better able to manage some modes over others)?
- Does cost recovery - particularly the levying of user charges at point of delivery - have an adverse impact on women's health?
- How do different types of cost recovery affect access to services by gender?

Equitable financing

Issues	Questions	Data sources and needs
Overall financing regime	*What are the financing mechanisms through which health care is provided?* *Are there potential gender imbalances in the access and coverage which they provide?* *e.g. the impact of user charges on access to basic services*	• National policies – ministries of health, finance, employment, social security • Field level research studies ❑ Extent of segmentation of financing mechanisms ❑ Gender breakdown of access and coverage

	Do reforms address equity implications of health financing modalities?	
Degree of socially distributed risk sharing	*Is the financial burden of reproductive costs shared across the population or does it fall mainly on women?*	• Data on public and private insurance schemes
Formal sector insurance schemes	*Who is covered and how does this relate to gender? Are there features of schemes which are discriminatory, e.g. requiring full time or uninterrupted service?*	• Data from government, employers' and private insurance schemes • Trade unions ❑ Gender breakdown of coverage ❑ "Typical" contracts
Community based financing	*Which groups are covered and for what services/ conditions? Are reproductive health needs adequately covered?*	• Data from national and local health bodies • NGOs and other voluntary sector providers ❑ "Typical" contracts
Safety nets/Micro-credit	*What mechanisms are in place to assist the very poorest to obtain health care? Does gender affect access to credit and safety nets?*	• National and local social security bodies • National and local credit schemes, e.g. Grameen banks, rotating funds ❑ Gender breakdown of participation
		❑

6. Equitable planning and priority setting

This benchmark is concerned with the planning process and how priorities get set by national and local authorities, for instance by the use of DALYs and cost effectiveness instruments. Some priority setting has also been influenced by international agencies, such as the implementation of Essential Services Packages. Moves to improve health equity through priority setting are very dependent on the availability and quality of data for monitoring purposes. In terms of gender, this depends on having a reliable evidence base. Planning that is sensitive to gender also entails recognition of the need to address sometimes hidden or contentious health issues, such as violence and adolescent reproductive health.

Equitable planning and priority setting

Issues	**Questions**	**Data sources and needs**
Information systems for	*What is the capacity of the*	• National and local

monitoring health inequalities	*health information system to monitor health inequalities by region, gender, socio-economic status or ethnicity?* *Will reforms improve HIS capacity for social monitoring?*	level data from health facilities ❑ Types of breakdown available – sex, ethnicity etc.
Evidence based planning, surveillance systems and forecasting for future needs	*Are planning methodologies sensitive to gender needs? E.g. are DALYs or other priority setting instruments used and has the issue of possible gender bias been considered?* *Is there any public consultation or participation in priority setting?* *Will reforms increase or diminish this?*	• Ministry of health policies and instruments • Local level planning instruments • Advocacy groups ❑ Views of informed official and civil society stakeholders
Basic and expanded packages	*Do these take account of reproductive health needs? What do they cover: a) in preventive care, b) in essential obstetric services, c) in tertiary level services, such as obstetric complications and emergencies?* *To what extent are dependents covered?* *Do the packages take account of adolescents' and other "invisible" health needs, such as gender violence?*	• National ministries of health policies and plans • International agencies, e.g. World Bank ❑ Extent to which the health needs of women, adolescents and other minority needs are recognised
Vertical v integrated programmes	*Are attempts being made to integrate reproductive health services?* *How is decentralisation affecting this?* *Do the reforms encourage integration?*	• National and local health bodies policies and plans • International agencies, e.g. UNFPA • Reproductive health research and support bodies ❑ Extent of progress on reorganisation and

		issues arising

7. Quality of care

This component is concerned with service improvement across a broad range of indicators, both technical and social. The poor quality of care in many health facilities has been implicated in low utilisation rates, particularly in some public facilities. Issues of choice and informed consent are also central to quality of care. Family planning services are a particular area of concern as some studies indicate that poor women are given fewer options and informed consent procedures are not always followed.

Quality of Care

Issues	Questions	Data sources and needs
Methodologies for improving QoC	*What tools are being used to strengthen QoC e.g. protocols, case conferences)?* *Are they sensitive to women's and men's different health needs?*	• National and local health bodies • Consumer bodies • Training and professional organisations ❑ Trends in service utilisation by different types of provider
Monitoring and supervision of health staff	*Are staff properly and regularly supervised?* *Are supervisers aware of gender issues in service delivery?*	• National and local health bodies • Training and professional organisations ❑ Views of staff on quality of support
Choice	*Does the delivery system enable users to exercise properly informed treatment choice?* *Is a full range of contraceptives available and accessible to both women and men?*	• Consumer bodies and women's advocacy groups • Training and professional organisations ❑ Views of users on information given and choice offered.
Informed consent	*Are health staff trained in informed consent procedures?* *Are contraceptive benefits and side effects explained fully to clients?*	• Consumer bodies and women's advocacy groups ❑ Staff understanding of informed consent ❑ Views of users on information given
Consultation and	*Are services monitored*	• National and local

satisfaction	*regularly from the point of view of client satisfaction? Are efforts made to ensure that women's views are obtained?*	health bodies • Consumer bodies and women's advocacy groups ▫ Extent to which services routinely monitor users' views and any follow up actions resulting

8. Equitable and efficient treatment of human resources

This component addresses the human resources aspects of equity and efficiency in health care. In the formal sector, human resources are critical to the capacity of the sector to deliver good health services. This requires well motivated and appropriately rewarded staff. The health sector employs many women but is characterised by low levels of women in senior positions. Privatisation is an increasing trend in many countries, especially the contracting out of auxiliary functions such as cleaning and catering to companies paying lower rates and fewer benefits. These workforce segments tend to be disproportionately female

Gender issues are thus particularly relevant to health human resources. Sex disaggregated management informations are essential to the development of gender equity policies for human resources.

Much health care however, is informal – delivered mainly by women in the family. This dimension of care is often invisible in official policy and planning. Women generally carry more of the care burden in relation to sick household and family members. Thus, adverse health impacts on e.g. children are more likely to affect mothers than other immediate adults. The household division of labour also tends to place greater burdens on women's time, resulting in higher opportunity costs for women in seeking treatment This component also reminds policy makers that informal care needs to be taken into account in health reforms, especially in the context of ageing populations. Issues such as reduction of hospital beds and of lengths of stay need to be considered from this point of view.

Equitable and efficient treatment of human resources

Issues	Questions	Data sources and needs
Human resources management information systems and policy	*Does the management information system provide sex disaggregated data on human resources? Is there an equal opportunities policy in place?*	• National and local human resources departments of health authorities ▫ Extent of availability of sex and age disaggregated personnel data
Levels of women in senior posts in the health sector	*What is the proportion of women in senior posts and where are they located?*	• National and local human resources departments of health

	What efforts are being made to increase the numbers of women at senior level?	authorities • Professional associations • Independent surveys ❑ Issues and obstacles in women's career advancement
Privatisation of health provision and moves to implement more flexible contracts in the health sector labour force	*Are new contracts being introduced in the public sector or through decentralisation?* *Do these contracts have more adverse impacts on female than on male staff?* *Do reforms take account of possible different impacts of employment policies on women and men?*	• National and local human resources departments of health authorities • Professional associations/trade unions • Independent surveys ❑ Sex disaggregated information on redundancies and restructuring
Retention of qualified staff	*Are terms and conditions "family friendly" to those with childcare and family responsibilities, and to staff who need to take career breaks?*	• National and local human resources departments of health authorities • Professional associations/trade unions • Independent surveys ❑ Retention rates broken down by sex and age ❑ Views of staff
Taking account of the needs of informal carers	*Do health reforms make assumptions about the ready availability of unpaid female carers in the home?* *e.g. policies to shorten hospital stay times, de-institutionalisation of the mentally ill, physically disabled, home care for the elderly and chronically sick*	• Policies on hospital closures/restructuring • Women's and carers' organisations ❑ Estimates of current burden of informal household care by socio-economic status

9. Democratic accountability and empowerment

This component is concerned with the extent to which health systems can be held to account by users and citizens. A fair health system gives people adequate information

and decision-making authority and holds all components of the system accountable for the decisions they make about delivery.

It affirms the important role of advocacy and consumer groups in creating accountability and in developing mechanisms of redress. Women's voices are often neglected in these processes and this component also addresses the different arenas in which attention needs to be paid to gender issues.

Democratic accountability and empowerment

Issues	Questions	Data sources and needs
Civil society involvement in holding bureaucracies and providers accountable	*Do citizens groups have a voice in planning, priority setting and monitoring of health services?* *Do reforms strengthen this involvement, especially at local level?*	• Citizens and consumer bodies • Professional associations ❑ Initiatives and consultation exercises carried out nationally and locally
Composition of health bodies	*Is there civil society representation on health bodies such as hospital boards?* *What is the proportion of female representation?*	• National and local health authorities • Citizens and consumer bodies Extent of civil society and female participation in formal health bodies
Citizens' rights to competent, equitable treatment and prevention of abuses	*Are mechanisms in place to ensure fair treatment of users, e.g. charters of rights, independent complaints bodies?* *Is attention paid to ensuring that the most disadvantaged groups, such as poor women, can gain access to these?*	• National and local health authorities • Citizens and consumer bodies • Professional associations ❑ Extent of safeguards in place and records of their use by women or their advocates
Improving information flows to the poor	*Are the needs of poor people, and particularly women as main consumers of health care, for good quality, easily accessible information on choosing providers and treatment being met?*	• National and local health authorities • Consumer and advocacy groups ❑ Availability of basic information in health centres, pharmacies and community centres
Transparency in resource allocation	*What are the formulas for resource allocation in health and how are they affected by decentralisation?*	• Ministries of health and finance • Local authorities • Women's and other advocacy groups

	Is information available to the public and in what form? *Are there means by which community and women's groups can raise issues or challenge allocations?* *Are there moves to produce a women's budget or gendered national accounts?*	❑ Views of civil society stakeholders

10. Progress towards meeting international commitments

International commitments on women's and children's rights are a very important way of holding national governments to account on the health of women and girls. This component is concerned with the implementation of these commitments through national and local machineries, and progress made in involving women's advocacy groups.

Progress towards meeting international commitments

Issues	Questions	Data sources and needs
Conventions, Platforms and Resolutions on health to which the government is a signatory	*Which conventions relevant to the rights of women and girls has the government signed?* *Are the appropriate ministries and local bureaucracies aware of their roles in implementation?*	• Parliamentary bodies • Women's groups ❑ Understanding of roles by official implementing agencies
Procedures to implement commitments	*What procedures are in place and what moves have been made to implement programmes of action on women's and children's health in the context of HSR policies?*	• International and national monitoring groups • Women's organisations ❑ Extent of progress in implementing Beijing and Cairo health objectives
Involvement of civil society/advocacy groups	*Are advocacy groups with knowledge and expertise involved in policy decisions, implementation and monitoring?*	• International and national monitoring groups • Women's advocacy groups ❑ Structures developed

		involving advocacy groups