

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

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

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

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

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

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

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

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

In Zambia, a Gender in Development Division within the cabinet was formed as the nerve center for all governmental policies on gender issues. However, the division's two senior staff have seemingly little decision-making power at the donor/national level or at the ministerial level. One of the challenges they face is resistance from top government officials to changing gender norms. For example, a local news report from 1999 states that in a parliamentary session, heated debates took place in which some male parliamentarians accused their female peers of "not keeping their homes in order." Incidents like this raise concerns about the way these transitions are enforced. Since resistance to changing gender norms is often found among the top-most levels of hierarchical systems, simply forming new administrative structures or writing new policy guidelines can do little to advance reforms (Nanda, 2000).

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

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

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

In conclusion, documenting the experiences of countries undergoing health sector reforms while simultaneously attempting to fulfill the goals of the reproductive health and rights agenda is critically important, especially for poorer countries in the early stages of reforms. A key element to improving the

impact of health reforms for reproductive health and rights issues is better global governance for health, increasingly recognized as a crucial factor in ensuring better health outcomes, especially for those who are most in need and most disenfranchised. In order to address these issues, institutions that engage in research and debate health reforms from a gender, equity and rights perspective need to:

- Strengthen civil society's access to information and its capacity to engage with institutional actors;
- Promote stronger regulatory frameworks to monitor health reforms;
- Develop evidence-based research on implications of current health reforms for the reproductive health and rights agenda;
- Monitor the implementation of key international mandates;
- Ensure greater sharing and dissemination of knowledge; and
- Promote opportunities for consensus building and transparency in decision-making on health reform processes.

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