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*The impact of health policies and health sector reform on the
readiness of health systems to respond to women's health needs, with
special focus on reproductive health, reproductive rights and
HIV/AIDS**

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* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations

1. Introduction

This paper examines how health policies and health reforms that have been implemented have impacted on the health and well-being of women, with emphasis on reproductive health, rights and HIV/AIDS. It tries to consider how health policies and reforms have tried to improve health systems to respond to health needs of women. Women's health has been the focus of both international and national state policies. However, many current health policies have tended to regard sexual and reproductive health and rights of women as insignificant. Further health sector reforms that have been implemented by many countries have tended to focus on their implications for the poor, with a few policy makers explicitly taking gender issues into consideration. What needs to be understood is whether the health sector reforms are reducing gender inequality. Some evidence suggests that reforms can produce negative impacts on maternal health service provision and use as changes can strain working relationships or overload health workers (MacIntyre and Klugman, 2003). Yet in other settings, indicators such as maternal mortality rates, decreased as a result of the reforms (Parkhurst et al, 2004). It has been observed that Health sector reforms are complex processes affecting the local systems in which individuals work – shifting incentive structures, regulatory mechanisms, and paths of accountability. They can also change the macro environment of health systems, reorganizing staff numbers and placements, and creating new structures and hierarchies within the health sector (Parkhurst et al 2004).

2. Health policies and health sector reforms

A health policy is defined as a program of action whose aim is to improve health conditions of the people. Health sector reforms are part of the overall economic, social and political reforms that began two decades ago. Health sector reforms have been implemented in an effort to improve health services management and supervision. These reforms are intended to decentralize health systems, reduce bureaucracy, and increase cost-effectiveness and efficiency in part by reorganizing services, streamlining management, and allocating resources to better meet local needs. Health sector reforms in developing countries have largely focused on health financing, organization and management of health systems, regulation and contracting out services. They have been implemented to improve efficiency and cost effectiveness in public health services (Jeppsson et al 2004). Some reforms were put in place to integrate the care provided by separate programmes to create efficiency and responsiveness to the user population. Some reforms have made significant changes to the way health services are organized and provided. Major health reforms that have been instituted include: Decentralization of governance to districts; health sub district approaches; civil service reforms; user fees; Sector-Wide Approaches (SWAPs); Unification of health and family planning services, and health care financing.

A major component of the health sector reform that has been implemented in a number of countries is decentralization of health services to regions, districts, voluntary agencies, parastatals and private sector. Decentralization of public service delivery systems and promotion of private health sector development have been some of the key measures undertaken in this regard.

3. Health system response to women's health needs: Reproductive health and rights, HIV/AIDS

Due to economic inequalities, especially in developing countries, women have difficulty in acquiring the basic necessities for a healthy life. There is considerable evidence to show that women experience gender-related constraints on their access to health services and that this affects the poorest women in particular. Since the eighties, policies have emphasized gender equality and the prevention of marginalization of women. The most serious obstacles to women's health and their rights are cultural, religious and social biases against women. These lead to barriers in accessing quality health information, education and services; and the inadequate allocation of governmental and donor resources (ARROWS for change, 1997).

3.1 HIV/AIDS

Women are more affected and infected by HIV/AIDS than men. About 38 million people are infected with HIV/AIDS worldwide, with 25 million living in sub Saharan Africa. Of these 25 million about 13 million are adult women and 9 million are men (UNAIDS, 2004). Given the often heterosexual dimension of the infection, the HIV/AIDS epidemic is particularly affected by gender systems and their inherent inequalities. It has been argued that gender systems in sub-Saharan Africa promote the spread of HIV through a variety of routes including masculine identities that support dominance, inequitable material resource allocation, widespread female poverty and economic dependence upon men (Kaleeba 1991). Through the decentralization reform, districts and local governments and communities have been equipped to handle HIV/AIDS prevention, care and support and mitigation activities, for instance in Uganda. The impact of health policies and reforms on the readiness of health systems to respond to effects of HIV/AIDS on women's health has not been fully investigated.

However using Uganda as a success case study, there has been a reduction of HIV/AIDS both in incidence and prevalence from 30% prevalence in 1992 to 7% in 2004 (MoH, 2005). Uganda adopted an open stance to the epidemic in 1986 to combat the disease and in 1992 launched a multi-sectoral approach involving NGOs, the donor community, private sector, academia, faith-based organisations, communities and civil society organizations. By September 2003, approximately 2,500 non-governmental organizations were involved in HIV/AIDS-related work in Uganda (Garbus and Marseille, 2003). Since the early 1990s, Uganda adopted a comprehensive behavior change approach that focused on abstinence, partner reduction and condom use. Survey data evidence over time suggest that the rapid decline in HIV/AIDS in Uganda can be attributed to change in all three key behaviors: increased abstinence and delay of first sex, decreased numbers of sexual partners and increases in condom use (Bessinger, Akwara and Halperin, 2003; Singh, Darroch and Bankole, 2003). HIV/AIDS care and prevention initiatives that were pioneered in Uganda, such as The AIDS Support Organization (TASO) programme, are also being replicated in a number of countries.

A health sector reform that affected most people living with AIDS in Uganda was cost sharing/user fees before it was scrapped. Introduction of user fees on health care services and other related expenses incurred in transportation and under table payment were making it exceedingly difficult for AIDS affected households to access medical care. Similarly non

affected households were affected by the fee, only that their medical needs were not as severe as those of the affected families (Asingwire, 2002). Further, implementation of exemption mechanisms at government health units was not functional and so it could not be relied on as a measure of accessing health services by people living with AIDS. Though the study did not look at the gender implications, it is obvious that most women were the most affected in this regard.

3.2 *Reproductive health and rights*

It is acknowledged that reproductive health, more specifically maternal health care, relies on the entire health system. Most important common system issues underlying maternal health care are human resource structures, public-private mix of service provision and the changes involved with health sector reforms. These influence the access to and utilization of services, quality of care provided and maternal health outcomes (Parkhurst, 2004). What impacts have health policies and health sector reforms had on women's health needs? This question is pertinent given that the goals of health sector reforms are complementary with those of the ICPD and the reproductive rights agenda. For instance both work towards a shift away from vertical toward integrated service delivery; seek to improve equity and increase access to services and; aim to enhance the role of local bodies in an effort to increase accountability to clients and other stakeholders. The impact of health care reforms may be evaluated by the extent to which they facilitate progress in equity and service integration.

In the health sector in Uganda, there are a number of policies with implications for maternal health service provision, such as the national health policy that has set maternal and reproductive health care as one of the priority areas, with reduction of maternal morbidity and mortality as key expected outcomes, and safe motherhood as a key element in the minimum health care package. The private sector has been brought on board to increase health care services and the public-private partnership policy has been instituted as a policy strategy for the increased decentralization of service delivery and the expansion of access to essential obstetric care at the community level. Further, some health facilities have been upgraded to cater for the new policy of health sub districts, which aim at improving access to the minimum health care package and decentralizing health service delivery down to the community level. At the health sub district level, emergency obstetric care, blood transfusions and post-abortion care is provided (MoH, 1999). However, there are still inadequate numbers of doctors and other personnel, and they have not been fully equipped.

Decentralization is intended to reduce inequalities in the provision of health care for more people to be able to access health services. In that vein, under Uganda's decentralized structure, the responsibility for the provision of health services, including maternal and child care for the 90% of the population that lives in rural areas rests on the district. Since 1997 efforts have focused on building district capacity to plan, implement and supervise maternal and child health and family planning services.

Macro-economic adjustment policies have brought gender issues into the limelight in Uganda. For instance there has been a mandatory representation of women on the health unit management committees, and it is reported that this has brought women's voice on board when decisions are taken that have a direct bearing on women's health. Decision-making about household health

issues that used to be the responsibility of men was reportedly slowly changing, partly due to community mobilization and sensitization (Bazeyo, 2001). On quality of care, the study found that the availability of properly trained medical personnel and equipment at health sub district where services such as maternity care and minor surgery were available had improved. However, at some units, expecting mothers are required to purchase their own gloves to be used in the labor wards because those officially supplied in the kit are inadequate.

How has women's health benefited from the health sector reforms? An examination of the indicators for maternal and reproductive health in Uganda show a general improvement in a number of indicators between 1989 and 1995 (UDH 2000), contrasting with the worsening or stagnation of some of the indicators between 1995 and 2000 (Ssengooba et al 2003) – see table 1. For instance, there has been significant improvement in access to family planning, and a growing demand for services. The maternal mortality ratio has also improved slightly since 1995. Other process indicators have seen marginal changes, and others, such as the proportion of women undertaking at least four antenatal care visits have declined between 1995 and 2000/2001 (Ssengooba et al 2003). There is a need, however, to undertake a clear analysis to determine how the current health sector reform strategies will improve or have improved reproductive health and rights in general terms.

Table 1. Indicators for maternal mortality and reproductive health, Uganda

Outcome indicators	Past Trends			Future Policy Goals (2004/05)
	UDHS 1988/89	UDHS 1995	UDHS 2000/1	
Maternal mortality ratio	700	506	505	Reduce by 70%
Neonatal mortality rate	-	27	33.2	Decrease by 30%
Total fertility rate	7.1	6.9	6.9	Reduce to 5.4
Infant mortality rate	119	81.3	88.4	
Process indicators				
Proportion of women delivering by skilled attendant (%)				Increase to 50%
Antenatal care (ANC) coverage (%)				
<i>In first 6 months</i>		48.6	55.4	
<i>At least once</i>		90.7	91.9	
<i>At least 4 times</i>		47.2	41.9	Increase by 15%
<i>At least 2 doses of TT</i>		53.7	41.7	Increase by 80%
<i>At least 1 dose TT</i>		80	69.6	
Caesarean section rate (%)		2.6	2.5	
Contraceptive rate – married women (%)	4.9	14.8	22.8	Increase to 30%
Unmet need of family planning (%)	52	21.9	35	-

Source Ssengooba et al 2003.

Ssengooba et al (2004) observed that at the clinic level, reforms seem to have created expectations – free care – but without providing the financial capacity for the policy to deliver sustained benefits. Drug shortages and an overloaded and demoralised workforce are elements in the health system that do not augur well for overall health sector performance. Health workers are viewed as internal customers of the health system; their dissatisfaction is likely to lead to a decline in the quality of services that will not satisfy the ultimate customers – patients, householders and communities (Ferrinho, Van Lerberghe et al., 1998). The user fees that were instated in a number of African countries have excluded vulnerable social groups from vital services, and the exemption systems have proved ineffective (Bedi et al 2003). However, in Uganda, user fee/cost sharing was abolished at public facilities in 2001 in order to encourage access to the minimum health care package, though at hospital level a two window - paying and non-paying - system has been instituted. The outcome has been that utilization of ambulatory services has increased, but the quality of services has decreased (Borghi, 1999).

4. Conclusions

Given limited evidence, it is difficult to make an empirically grounded assessment of the impact of health sector reforms on women's health. Evidence based information is scanty on the causal pathways that link complex reforms such as decentralization or sector-wide approaches to health financing, which actually impacts on maternal services (Parkhurst et al 2004) and how key health systems characteristics affect reproductive health and HIV/AIDS care. More information is needed on whether current reform strategies promote or hinder gender equality and reproductive health and rights; whether reforms have led to increased access to essential technologies by the poor, and particularly by economically marginalized women; how reforms are affecting critical health programs and services, such as access to safe abortion, access to STI diagnostics and treatment, and access to contraceptive supplies; and the impact of the reforms on quality of care in developing countries.

However, it is noted that health sector reforms and policies have had both positive and negative effects on women's health but this is dependant on the type of reform and is country-specific. Some reforms have improved women's access to health care while others have made it difficult and have compromised on quality of services, e.g. scrapping of cost-sharing in Uganda. Policies need to be built through bottom-up rather than top-down processes, as access to and utilization of, health services are heavily influenced by cultural and ideological factors. If not well thought-through, health sector reforms may only worsen women's overall position and health.

The reproductive health agenda in developing countries has been met with challenges of HIV/AIDS pandemic. So a reproductive health agenda should consider the socio-economic challenges and consequences of the HIV/AIDS pandemic.

Women themselves will need to be more involved in the design, implementation and evaluation of services. Because of the relative absence of women from most of the important arenas of decision-making, special care may have to be taken to ensure that their views are heard. They should be educated on these reforms so that they participate in current health care reforms.

Perceptions and experiences of women regarding health sector reforms and policies such as user fees, and how they affect women's access to healthcare, need to be investigated from systemic perspectives.

It is clear that gender issues should be a central concern in health sector reform because women are found disproportionately among the most vulnerable population groups. Economic and financial changes in service delivery brought about by these reforms may have a disproportionate effect on women.

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