Bypassing districts? Implications of sector-wide approaches and decentralization for integrating gender equity in Uganda and Kenya

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While the concept of gender mainstreaming has gained acceptance among many national and international development organizations, many obstacles are faced in translating the concept into tangible improvements in the health and well-being of women and men. This paper presents two qualitative case studies, one from Kenya and one from Uganda, of experiences of mainstreaming gender at district level; experiences which are set against the context of decentralization and sector-wide approaches (SWAps). The conceptual framework of social movement theory, as used by Hafner-Burton and Pollack, is drawn upon to analyze the findings of both case studies. This paper has been written in conjunction with a paper by Theobald et al. which explores gender mainstreaming at national level.

Key words: sector-wide approaches, SWAps, gender mainstreaming, decentralization, districts

Introduction

Gender mainstreaming has grown in acceptance as a process through which development organizations—both governmental and non-governmental—can address gender within every aspect of their work. It is at district level that gender-mainstreaming policies need to be translated into concrete changes to improve the health and well-being of women and men. This paper presents two qualitative case studies, one from Kenya and one from Uganda, of experiences of mainstreaming gender at district level; experiences which are set against the context of decentralization and sector-wide approaches (SWAps). The conceptual framework of social movement theory, as used by Hafner-Burton and Pollack, is drawn upon to analyze the findings of both case studies. This paper has been written in conjunction with a paper by Theobald et al. which explores gender mainstreaming at national level.

Decentralization and sector-wide approaches (SWAps)

Decentralization and, increasingly, sector-wide approaches (SWAps) have dominated health sector reforms over the last decade or so. SWAps were developed in the 1990s in response to the relative ineffectiveness of a multiplicity of poorly coordinated donor projects. Ideally, in this approach the government takes the lead in negotiating with donors to develop coherent policy and expenditure programmes within a particular sector. Donors then contribute to a single pool of funding to support the development of the entire sector, within the framework of a locally owned strategy and approach (Cassels 1997). While SWAps generally concern themselves with resource allocation decisions and priority setting at the national level, decentralization processes promote decision making and priority setting at the local and district levels (Peters and Chao 1998). Several authors identify these different foci as causing considerable tension between the processes of SWAps and decentralization (Norton and Bird 1998; Jeppsson 2001).

In Uganda a policy of decentralization in all sectors, including health, was first introduced in 1993 and further developed in the 1997 Local Government Act. Uganda is clearly moving towards a devolved structure (Collins 1994). District Authorities have gained full responsibility for the delivery of health services, recruitment and management of personnel, passing of by-laws related to health planning and budgeting, and importantly, mobilizing additional resources and deciding their allocation (Government of Uganda 2000). However, the realization of this level of devolution has not been without problems. In particular, the resistance from central ministries to what has been seen as a loss of power has led to more limited decentralization, or deconcentration (see footnote 2 and Collins 1994), especially in poorly resourced areas (World Bank 2000).

The SWAp process began in 1998 with the development of Uganda’s Health Sector Strategic Plan (2000/01–2004/05). Most bilateral donors are fully committed to the approach...
In Kenya, Ministry of Health documents currently indicate a general movement from a vertical, fragmented approach to aid towards national planning in the health sector. However, Kenya is only at the beginning of the long process of SWAp implementation. The focus of health sector reforms has been on decentralization, aimed at generating increased financial resources through user fees and further strengthening the government’s services ‘in a manner consistent with the objective of reallocating resources to favour the rural population and women’ (Government of Kenya 1999). While decentralization was initiated in the late 1970s, it has taken considerable time for its realization in practice. A major step towards decentralization was the establishment of District Health Management Boards (DHMBs) in the late 1980s. These faced initial limitations due to a lack of authority over personnel or budgets (aside from prioritizing needs to be met with funds available from user fee income). More recently, DHMBs have been given greater responsibility to oversee planning, governance, management and development of health services, and the allocation and distribution of government and additionally generated health care resources, making recommendations on expenditures and budgets to District Development Committees. In 2001, Owino et al. found that DHMBs still faced considerable constraints, reporting that they ‘lack the requisite capacity to undertake many of the new functions’. They also have ‘limited autonomy to perform control functions’. In all, many of the Boards have tended to be ‘inconsistent and ineffective’ (Owino et al. 2001). The direction that health sector reforms will take under the National Coalition government elected in 2002, and in particular whether or not the SWAp process will be accelerated, are unclear at the time of writing.

Gender mainstreaming

The call to mainstream gender has grown ever louder since the adoption of the Beijing Platform of Action in 1995. This reflects the move from earlier paradigms advocating the integration of Women in Development (WID) to an emphasis on power differences between men and women which underpin the Gender and Development (GAD) approach.3 Theobald et al. (2005) discuss the ascendency of gender mainstreaming and its adoption by most governments and international organizations, but note that the concept is still described as ‘fuzzy’ (Booth and Bennet 2002), particularly in the areas of its final goals, processes of evaluation and criteria for success. As a starting point, the Beijing Platform for Action elucidates mainstreaming as a process where:

‘Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that, before decisions are taken, an analysis is made of the effects on women and men respectively’ (Beijing Platform for Action, 1995 cited in Derbyshire 2002).

True and Mintrom (2001) have identified both Uganda and Kenya as having ‘high level’ mechanisms for gender mainstreaming, because they have stand-alone national government ministries concerned with gender; in Uganda this is the Ministry of Gender, Labour and Social Development (MoGLSD) and in Kenya the Ministry of Gender, Sports, Culture and Social Services (MoGSCSS). At district level both countries have also established some human resource structures for mainstreaming gender. In Kenya this has taken the form of Units of Gender Issues (UGIs), and in Uganda each district authority has a staff member with gender mainstreaming as part of their other responsibilities, often the Community Service Manager.

While there are differences in the policy environment in the two countries, over the last decade, both have moved towards decentralization and both have also established relatively ‘high-level’ national mechanisms to take forward gender mainstreaming. Although the two studies were not designed as a comparison, combining the data from both studies highlights some of the common challenges in mainstreaming gender, as well as the differences in opportunities offered by different policy environments and structures.

Methods

Uganda

The Ugandan case study is based on qualitative research carried out between April and July 2002 in a district in Eastern Uganda. A review of government, non-governmental and donor documentation was undertaken. Semi-structured interviews were held with two male and two female members of the District Health Team, the Community Services Manager (female) with a responsibility for gender, five (four male and one female) national and international NGOs based in Eastern Uganda, four female and two male health centre staff of all levels in the district and the chair (male) of a community health committee for one health centre. Participants were selected purposively to seek out ‘information-rich cases’ (Patton 2002) to illuminate perceptions of gender and experiences of the constraints and enabling factors to gender mainstreaming within district health authorities in the environment of SWAps. All interviews were conducted by the first author and focused on interpretations of gender within health, the changes SWAps had brought for various stakeholders in the district and their implications for mainstreaming gender. Where consent was given, interviews were recorded and transcribed.

An action-planning workshop was held for district health staff to discuss progress in addressing gender and to identify ways forward. This workshop provided a valuable source for triangulation with the interview data, as, during the action-planning process at the workshop, the health staff spoke more
openly about their perceptions, priorities and challenges in addressing gender than they may have felt able to do during the interviews. All data were analysed using a framework approach (Ritchie and Spencer 1994), which after a coding process, built themes inductively from the data as well as deductively from the research objectives.

Kenya

The Kenyan case study also used a qualitative approach. Information was gathered between May and August 2002 from two districts, Kwale and Kilifi. These districts face great gender inequities and are among the poorest in the country. The primary interest was in exploring experiences of SWAps and decentralization, civil society participation, and challenges to mainstreaming gender and achieving equity. Participants were purposively selected to capture diverse experiences of district-level health care planners, managers and service providers. Individual in-depth interviews were held with four DHMB members (two males and two females), three male District Health Management Team (DHMT) members, and five staff working in NGOs and health centres (two male and three female). Natural group discussions with staff working in three health centres in Kilifi, and with members of the District Health Stakeholder Forum in Kwale, were also held. All interviews and group discussions were undertaken by the second and the last author, who supplemented the information with 11 years of experience of working at the district level in the two Kenyan districts (including training district-level staff in gender mainstreaming for community development, and working in governmental and non-governmental positions in the health and social sectors). Identification of key themes was continuous throughout fieldwork, with common and unusual perspectives within each theme identified and highlighted through direct quotation.

The findings: through a social movement lens

The concepts of social movement theory identified by Hafner-Burton and Pollack (2002), particularly those of mobilizing structures and strategic framing, provide a valuable lens through which to view the findings of the Kenyan and Ugandan case studies. District-level structures introduced specifically for mobilizing the response to gender are addressed first, followed by civil society structures. Within each of the structures, the strategic frames used by different stakeholders to interpret and address gender are discussed.

Gender mobilizing structures at district level

Mobilizing structures within social movement theory have been defined as ‘those collective vehicles, informal as well as formal, through which people mobilize and engage in collective action’ (McAdam, McCarthy and Zald cited in Hafner-Burton and Pollack 2002, p.347). In the case studies from Uganda and Kenya, these vehicles or driving forces can be divided into two main groups. The first comprises gender advocates within the local government system; here we focus on those employed within the district whose mandate includes advocating and supporting district staff from all sectors, including health, to respond to the differing needs of men and women within their core work. The second group comprises those outside the government–community members, community-based organizations (CBOs), non-governmental organizations (NGOs) and donor partners—who play a role in influencing government to address gender, and who themselves implement development work shaped by gender and equity concerns. This second grouping is diverse but also interlinked, as community members may be associated with local CBOs or NGOs and the priorities of NGOs and CBOs may be strongly influenced by the priorities and perspectives of donor partners (Kardam 1997). Hence, these categories are explored together in the sections below.

Structures for mobilizing the response to gender within district government

Uganda

Within the Ugandan district authority studied, the Community Service Manager held responsibility for mainstreaming gender within all departments, including health. The research highlighted how SWAps had brought about changes in the level of support she received to mobilize others in the district authority to address gender issues in their work. First, SWAps encourage a reduction in donor support for specific projects in favour of central budget support. Before the advent of the SWAp, an international NGO (INGO) identified gender issues as a key constraint to health development in the district and provided gender training for district officials and local politicians, and a gender strategy was developed for the district (interview with former INGO Coordinator and review of documentation). The project ended as the health SWAp became established, and this type of external project funding can no longer be relied upon for supporting gender-specific capacity building at the district level.

The second change that SWAps has brought to the avenues of support for gender mainstreaming is the reduction in capacity—both human and financial—of the MoGLSD. Established to provide training, technical assistance and support on gender issues to sector ministries and district authorities (particularly the focal points), the MoGLSD has not received budget support through the SWAp process. As illustrated by Mpagi (2002) in Uganda, the advent of SWAps has meant greater focus and resources for core service-delivery sectors such as health and education, which has put a strain on resources available for the national gender machinery. As a result, district gender focal points charged with mobilizing the response to gender receive very little, if any, support from the national gender machinery or from external projects. This has caused frustration among focal points and others in the district keen to take forward their gender strategy and made them question the value of SWAps:

“The district does not have any funding [externally generated from donors or taxes]; all our money comes from the centre and from Poverty Action Fund [fund for
While it is clear that SWAps have caused significant changes in the financial and technical support available for mobilizing a gendered response within the district, the logic of the theory that SWAps can build strong national capacity to implement sustainable, nationally owned responses is hard to refute. Merely calling for a return to the days of a multiplicity of donor-funded projects, whilst attractive in the short-term, can no longer be a viable long-term solution. The INGO project within the district had made considerable attempts to establish a sustainable process to facilitate all of the district teams, including health, to address the differing needs of men and women in their core work. However, this research highlighted the lack of long-term influence that the strategy or training had had on current activities or plans of the District Health Team. The blame for this ‘policy evaporation’ (Derbyshire 2002) of the district’s gender strategy cannot be laid only at the door of SWAps; there are clearly greater challenges to firmly institutionalizing a gendered response within the work of the district.

Kenya

The experiences from Kenya offer some insight into factors that have influenced gender mainstreaming at district levels. When the Women in Development paradigm dominated thinking on gender, Units of Gender Issues (UGIs) were established in sector ministries. These officers were mandated to address gender issues in their sectors. Most UGIs were located at the national level, with few ministries appointing UGIs at local level. Some of the officers had no interest in or knowledge of gender issues and they were often not supported through policy, operational action or budgetary provision. Initiatives tended to be vertical (from the sector) and there were no forums for UGIs in different ministries to share experiences and enhance coordination, particularly in the districts. A gender advocacy role was an add-on to their existing jobs and thus not a priority.

A new approach, using gender focal points with a sole mandate to mainstream gender, was initiated and supported through the UNDP/Government of Kenya country cooperation framework (1999–2003). At the time of the study, 10 districts of 72 in Kenya—including Kilifi but not Kwale—had three gender focal points (each covering at least three districts). They were situated in the Ministry of Gender, Sports and Culture. According to interviews with a senior UNDP official, the visibility of gender considerations in district development plans in three of the 10 districts increased as a result of the gender focal points. For example, district plans reflected more gender-dissagregated information for planning. Women’s representation in development at community level also increased, though it is unclear what effect, if any, this may have had on ensuring that gender issues were addressed. However, effective input into sector plans, including the health sector, at district level was lacking. Line ministries continued independent gender initiatives, trickle down of resources to the district was slow, and the focal points were expected to cover large working areas with limited support. In addition, focal points did not have a clear mandate to create horizontal and vertical inter-linkages between different ministries at the decentralized district and between the national and local levels.

The experience of both countries highlights the limitations of gender mobilizing structures within district government. While in Uganda, SWAps appear to have undermined support, both financial and technical, for gender mainstreaming, in Kenya, where gender focal points have been supported and have gender as part of their core mandate, the visibility of gender in district development plans increased. However, extending this gendered response to the work of the various sectors, such as health, is still a challenge. The following section looks at the extent to which civil society has been able to raise and address gender issues at district level.

Gender mobilizing structures outside government: civil society

As identified above, structures for mobilizing gender concerns extend beyond gender advocates within government; civil society organizations and community actors have a vital role to play in voicing the concerns of men and women to influence an effective response from government and other actors. In Uganda, civil society has been at the forefront of thinking on women’s empowerment and gender issues. Furthermore, SWAps, at least in theory, encourage the input of civil society in both the design and monitoring of government sector policies and practices. This places civil society in a strong position to influence government, at both national and district level. However, interviews with NGO staff working on gender indicate that they rarely extended their advocacy work to health issues. Several reasons were given for this. First, NGO members felt intimidated and reluctant to confront the powerful medical fraternity:

“There is a real mystery around health, even for us; it is easy to be intimidated. The first thing they ask is ‘are you a doctor?’ but I am a health consumer, and from the consumer point of view I have a contribution to make.”

(interview with NGO worker, female, Uganda)

In Kenya, government personnel had concerns about the legitimacy of civil society actors in representing communities, as many felt that the mandate and interests of many NGOs and CBOs do not reflect either district or community level priorities and merely increase the potential for conflict, replication and confusion between NGOs, government and communities. Concerns have also been raised about the multiplicity of community committees, often with the same community representatives on each committee, which further adds to the complexity. At grassroots level such challenges are reflected in the limited visibility of development activity and increased community disillusionment:
are challenging questions about addressing gender when output structures themselves are weak, an analysis of the openness of input structures is helpful in identifying opportunities and constraints facing those outside government in raising gender issues within health.

At district level in Uganda, the main input structures for social movements are district-level committees that include civil society representatives and organizations, such as NGOs. However, interviews with district and NGO staff highlight how the aim of these structures is the coordination of services; they may not facilitate a two-way flow of information where NGOs can make inputs needed to influence local government.

“It would appear that while the district authorities may be keen to provide advice and ensure coordination, they are not as yet ready to accept the role of civil society organizations in advocating the health needs of women and men.

In the Kenyan health sector system, the greatest opportunities for community participation, and particularly women’s representation, appeared, at the time of writing, to be at the lowest tier of the public health system: dispensary committees. These committees consist of elected representatives with their own bank accounts and a remit to make decisions and act ‘on the spot’. While there has been improved representation of women at dispensary levels, this pattern does not appear to have extended up the hierarchy, even to health centre level (the next level up). The incorporation of both men’s and women’s concerns into government health planning and implementation is further complicated by having three parallel and poorly coordinated systems: these are structures in the health sector, in local government and the district systems.

The DHMB, which includes public representation, has the potential to be used by communities to influence the DHMT expenditure plans. However, it is questionable how far the DHMBs address gender issues, particularly where women are inadequately represented on the Boards. For example, in one of the case study districts, the two women officially sitting on the DHMB said that they had never been invited to meetings, despite living within a few doors of the chairman. The extent to which members represent their communities is also questionable, as members were generally selected by the District Medical Officer of Health (DMoH). Furthermore, the role of the DMoH, who is also a member of the DHMT, in selecting the members was said to undermine the independence of the Board and hence their ability to challenge DHMT plans and practices. This compliments the findings of Owino et al. (2001), presented earlier, on the lack of capacity and authority of the DHMBs to intervene in DHMT activities.

The District Health Stakeholders’ Forum (DHSF) is a recent addition to the organizational structure at the district level in Kenya. This aims to coordinate and reduce duplication of
efforts through enhanced collaboration. In one of the case study districts, the DHSF had been operational for 2 years, had external funding and met every 2 months. Attendance at meetings was high, improving coordination and communication to facilitate the delivery of critical services, the extension of coverage and the sharing of workloads between stakeholders. Notwithstanding concerns of sustainability, this offers considerable potential for developing a local level, coordinated, gender mainstreaming strategy, although no explicit efforts have been made towards this.

There is some way to go before the input role of civil society organizations as a channel for the concerns of the poorest and most vulnerable, particularly women, meets with a high degree of openness within local government, which can also be matched by effective output capacity and commitment to respond to concerns raised.

**Strategic framing of gender at district level**

Social movement theorists have identified how advocates for change make use of a number of ‘strategic frames’ to develop their understanding of an issue and to ensure they can influence others to take on this understanding. Strategic frames are described as ‘the conscious strategic efforts by groups of people to fashion shared understandings of the world and of themselves that legitimate and motivate collective action’ (McAdam, McCarthy and Zald cited in Hafner-Burton and Pollack 2002, p.348). Theobald et al. (2005) explore differences in strategic frames used by bureaucrats, civil society and academics when conceptualizing and addressing gender. Attempting to understand the ‘frames’ used by the various stakeholders identified in Uganda and Kenya from government, non-government and the community helps to shed further light on some of the constraints to mainstreaming gender at district level.

The interviews with the District Health Team in Eastern Uganda framed gender within a Gender and Development approach, showing an understanding of the influence of gender on social and economic relations at community level. District Health Team members attributed this to the INGO’s gender training. Some members of the team identified how this understanding of gender issues had influenced local authority thinking on the issues they should respond to:

“We always talk about men and women, and everyone talks about early marriages, and teenage pregnancies, which shows they are concerned about gender and health.” (District Health Team member, male, Uganda)

However, the predominant response among the District Health Team was to frame gender issues within reproductive health:

“We are doing reproductive health, which is an activity that is addressing gender, sexual health, men, woman and children.” (District Health Team member, female, Uganda)

Although a focus on reproductive health is positive in itself, it has its roots in the Women in Development approach, where gender is interpreted predominantly as ‘projects for women’. There was very little evidence at district level, or indeed at central Ministry of Health level, that this thinking had moved on to a recognition of power differences between men and women and how these differences affect health-seeking behaviour, vulnerability to illness and disease, access to treatment and care for communicable diseases.

Difficulties in making this leap from the Women in Development approach to a gendered analysis strategically framed to be of relevance to all areas of health may well be contributing to the evaporation of gender policy within the plans of the District Health Team. Differing sectoral ‘frames’ may also play a part: the community services manager felt unable to ‘strategically frame’ gender issues within the dominant paradigms of the health workers, saying that she felt she did not “speak the same language” as the District Health Team. At the time of the case study, there was no gender focal point with a health background employed within the District Health Team itself. However, plans were being discussed for a member of the health team to take on responsibility for addressing gender within the health work. This may well help in developing a new strategic frame, where gender is understood in relation to all aspects of health, rather and women’s sexual and reproductive needs alone.

The Kenya case study indicates that even strategically framing gender within the discourse of health may not be sufficient at district level. Gender must also be strategically framed within the local context and experience. The drive for gender equity has often been seen as a donor-driven concept with no links to local realities. It was described by some DHMT and NGO interviewees as “just another paradigm shift in development meant to replace the forgotten Women in Development approach” (DHMT, female, Kenya); as “not very different from the general concerns on women issues” (NGO worker, male, Kenya); and as “a new fight for women against men” (NGO worker, male, Kenya).

However, during interviews, local staff demonstrated a clearer understanding of the effects of gender power relations, and saw the benefit of responding to the different needs of men and women as central to meeting their essential health service objectives for the community. For example, interviewees attributed the poor uptake of maternal services at village levels in part to women’s limited sexual and financial decision-making. One informant commented that:

“Everybody sees these problems and feels them, but they do not necessarily see them as gender issues but as real day-to-day problems as they are increasing poverty at the household.” (NGO worker, male, Kenya)

This raises a key issue--that while gender issues are framed in the language of outsiders, they are unlikely to have any impact on the hearts and minds of district-level stakeholders, from community members to civil society organizations and district authorities. Strategically framing gender issues in the everyday gendered experiences of local communities may better enable gender equity advocates to articulate, and potentially implement, a ‘home-grown’ response to gender within health and beyond.
Conclusions

The two studies present the opportunities and challenges that both decentralization and SWAs bring for addressing gender issues within local government health plans and practice. While it would appear that SWAs may initially undermine some of the traditional sources of support for gender mainstreaming at district level, a closer look reveals how, rather than reverting to a hotchpotch of donor projects, the real need is to develop more sustainable and institutionalized structures to address gender at both national and district level. Whilst Kenya is still at the early stages of SWAp development, this is an ideal time to ensure that donor projects which address gender take as their primary goal the challenge of institutionalizing gender within government structures. In Uganda there may be a need for some degree of external donor funding beyond budget-support to kick-start the process. Processes aimed at institutionalizing gender would do well to encourage sufficient ongoing support to gender focal points, with job descriptions that clearly provide for a focus on gender mainstreaming. Ensuring that performance indicators are firstly disaggregated by sex, and secondly include a measure of progress towards gender mainstreaming that goes beyond the number of women on committees or the number of reproductive health programmes, could also help to encourage a sustainable gendered response within the health sector.

Both studies show that civil society organizations and fora have some way to go before becoming an effective structure for mobilizing and campaigning to address gender within District Health Teams. Furthermore, the input structures of district authorities were found to be either ineffective or only able to provide advice and coordination, rather than acting as a point where external actors, such as NGOs and community representatives, could channel the health concerns of women and men. The Kenyan example illustrates how decentralization has led to the creation of new structures and committees, many of which provide space for community and civil society representatives. This offers considerable opportunities for the development of channels through which poor men’s and women’s differing health needs can be represented and responded to by district-level players.

The key to institutionalizing gender within the hearts and minds of district staff, and the structures they develop and work through, may be in changing the way gender is framed. There is an urgent need to move away from gender as it is framed by outsiders, to a home-grown approach. These lessons would seem particularly pertinent for those developing gender training—often criticized for being too heavily based on gender theory rather than applied to health and local realities (Howard 2002). Strategically framing this home-grown approach within the language of health would further help gender advocates within and outside government to have greater influence on the health sector.

Endnotes

1 Both papers have been developed following the organization of a workshop for Ministerial gender focal points at central and district levels and NGO representatives working on mainstreaming gender in SWAs from eight different countries. The workshop took place as part of the 8th Women’s Worlds Conference, 23–24 July 2002, held at Makerere University, Kampala, Uganda. A resource pack containing all the edited papers presented at the workshop, an introduction, conclusion and policy brief, is available online at: [http://www.liv.ac.uk/lstm/research/GHRResourcePack.htm].

2 A devolved structure commonly involved constitutional change to allow local government units to raise revenue, allocate funds and have considerable decision-making authority. Deconcentration is the most limited form of decentralization where some form of administrative authority is given to lower levels of government, but the periphery remains subordinate to central government (see Collins 1994 for more details).

3 For a discussion of the conceptual and practical differences between these, see Buvinic (1986), Rathgeber (1990) and Beall (1998).

References


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