GENDER AND THE PRODUCTION OF HEALTH CARE SERVICES: ISSUES FOR WOMEN'S ROLES IN HEALTH DEVELOPMENT

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1 INTRODUCTION

The preservation of good health and care of the sick, disabled and dying accounts for a substantial share of national activities in even the poorest countries. Health is a labour intensive sector which involves work at a number of levels of organisation: within households, in communities, by workers in the informal sector as well as in the modern health services. A large percentage of the inputs are made by women. In many developing countries, health sector strategies have been formulated, in the absence of basic information on how these services are produced.

Two developments during the past decade have led to an increased interest in the production of health care services; the acceptance of primary health care (PHC) as a strategy for sectoral development and the economic crisis. The article addresses the implications and effects of these in relation to women.

1.2 Primary health care and the role of women

Since the publication of the Alma Ata Declaration in 1978 (WHO 1978) there has been an increasing acceptance of the PHC approach. Almost all of the tasks which it identifies as 'essential' have traditionally been in the domestic sphere (e.g. health education, improving nutrition, access to clean water, immunization of children, basic care of pregnant women and young children, family planning, and provision of basic curative care).

Women are the principal producers of health-related services at household level. They are the family health educators and they play the major role in the production, harvesting, processing, storing, preparation and distribution of food for their households. In many countries women haul water and manage basic sanitation in the family and the community. They play an important role in the promotion and use of immunization, the management of pregnancy and the care of children. They also treat injuries and common diseases and provide nursing care for the more seriously ill and disabled (Butler 1983).

The PHC approach stresses the importance of the mobilisation of local communities to undertake health-related work, where the assumption is often made that women will provide the resources, the time and the skills for these activities. Women have played a major role at this level by cooperating around tasks of water management, pit latrine construction and sanitation programmes, nutrition and literacy projects, communal child care, campaigns to prevent deforestation and to close down liquor shops, as well as in mother and child health programmes. At the community or village level, women have also played a role as providers of health services in the informal sector, particularly as traditional birth attendants, and more recently as Community Health Workers (CHWs).

Women constitute a substantial proportion of the labour force in the modern health services. There has been a rapid expansion in training of middle-level cadres such as nurses, paramedics, and midwives, professions which are often predominantly female. In many countries the unskilled and semi-skilled personnel who perform much of the cleaning and patient care in hospitals are women. However, men usually still constitute the majority of doctors.

There has been a considerable amount of research on women and health in developing countries in recent years. However this has focused largely on (poor) women as consumers of reproductive health care. Proposals have been developed to make services more accessible and sensitive to their needs. The role of women as producers of health care services has received much less study, with the notable exception of the recent WHO monograph (Pizurki et al 1987). There is a need for research into the implications for policy of the important role of women in the health sector.

1.3 The impact of economic crisis

The economic crisis and its effect on public health services has given an added urgency to the need to understand how health care services are produced. There has been a tendency to shift the burden on to communities and individual households (UN Sub-Committee on Nutrition, 1990).

Where charges for PHC have been introduced, or increased, women in poorer households have had to choose between decreasing their use of health services or finding additional cash (either through increased income generation or diminished expenditure on other goods and services).

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The more common response to the crisis has been a cut in the level of service delivery by the public sector and an increase in the role of households and the informal sector. There has been a substantial decrease in the use of government clinics due to lack of staff, drug shortages, and the deterioration of facilities in a number of countries. The quality of services is frequently low and there has been a shift toward the informal sector (traditional healers and semi-legal practitioners and self care (van de Geest et al 1990; Whyte 1989 and Banguire 1989). Where hospitals are perceived to be dangerous places, women are more likely to nurse their sick family members at home. Many programmes, targeted at specific health problems (children with diarrhoea, the disabled, people with AIDS), envisage a substantial and increased role for home-based and predominantly female care and support.

The economic crisis has had an impact on women as health workers as well. Levels of public sector pay have fallen considerably in many countries. The morale of health workers who work in inadequate facilities with virtually no supervision is low (Simmonds 1989) and there is a risk that significant numbers of health workers will become de-skilled (UNDP 1983). The (re)-establishment of a cadre of effective health workers is one of the highest priorities for many developing countries. This provides an opportunity for (or threat of) substantial restructuring of the work force. Questions such as the relative responsibilities of different cadres, pay and career structures, relationships of authority, relative roles of the private and public sectors, and the role of professionalism and professional bodies will be increasingly important in years to come. This article argues that the role of gender in the restructuring process as a basis for a future alliance for health, needs to be addressed.

2 THE ROLE OF GENDER IN THE PRODUCTION OF HEALTH CARE SERVICES

The remainder of this article will identify some key areas where gender-sensitive research can contribute to a better understanding of policy options. The aim is to open up a debate on the role of gender and gender politics in the production of health care services. The discussion will be structured around four levels of organisation of the production of health care; households, communities, the informal and formal sectors.

2.1 Women as carers in households

The importance of women as producers of health care services within households is increasingly recognised by researchers and international organisations. Their tasks include routine care of children, treatment of minor illness, long term commitments to care for old and disabled family members and the need to cope with catastrophic illness when it strikes.

The industrialised countries have developed a wide variety of institutions to organise a reduction of the burden on individual families (although they have come under financial stress in recent years in the UK). In both cases an assumption has been made that women, as home based carers, have no labour constraints that would limit their capacity to take on the production of health care services within the household. However, a number of studies have shown that women operate with labour constraints in their multiple roles in production and reproduction and are increasingly being squeezed with fewer resources and more demands on their time (Elson 1989).

Very few studies have been done on household caring patterns in developing countries. For example, studies on women's caring roles in relation to child survival found almost no direct empirical data on the time costs to women of breat feeding, immunizations, oral rehydration therapy, or growth monitoring. However there are indications that labour constraints are an important determinant of utilization of these technologies (Leslie 1989; Chattergee 1991).

2.2 Women in the community

The literature on PHC frequently makes reference to the importance of 'the community' in the production of health care services, particularly in relation to mobilising activities for public health campaigns, financing health services and CHWs and organising itself in effective health committees.

The use of 'community' today in most cases refers to locality, where in most cases it can no longer be assumed that, within a given area or a village, people are homogeneous groups of individuals. In any area where modern health services exist, production and distribution systems are based on market exchange, where social stratification and differentiation have transformed rural areas into heterogeneous villages, with different socio-economic groups. In addition to these socio-economic groups, villages were already divided into different ethnic, clan, religious and caste groups that all involve different sets of obligations and roles. Also in all populations there are gender differences where the socially constructed roles between men and women determine the sexual division of labour in that community or population. The diverse groups have different access to resources, different survival strategies as well as different health care needs (Rifkin 1985). The complexity of local organisation has meant that strategies for the creation of effective organisation around health at this level have been poorly articulated.

However there are numerous examples of local or village based actions around health issues where the resources coming into the area in terms of a CHW, a loan, a training programme have been an important catalyst for change, triggering a demand and supporting people in the articulation of their needs. Many of the reportedly most successful community health projects have depended on charismatic leaders usually operating within NGO projects, where political commitment, flexibility, innovation, flexible resources, improved training and management have led to positive changes involving women's roles in the community (Halstead and Walsh 1987).

The descriptions of these positive examples however, often do not explicitly explore the gender dimensions of local participation. For example, in most countries Village Health Committees are made up of men representing the power in the village and choices made by these committees on the siting of new shallow wells, bore holes or Village Health Centres or the choice of candidates for training as a CHWs, or the introduction of drug financing schemes are made by them. These decisions usually represent the interests of the power groups in the village not the poorest sections and certainly not the poorest women, whose need is often the greatest.

Women in villages with new PHC activities carry out the extra health related tasks, while the village men are involved in the decision making processes, usually through Village Health Committees, in relation to any aspect of financing health care services or activities and any other organisational matters.

There is a need for serious research into the gender aspects of the roles of localities or 'communities' in organising themselves to produce or pay for health care services.

2.3 The informal sector

Workers in the informal sector including traditional healers, CHWs and birth attendants are important producers of health care services, and a large number of these are female.

Traditional Birth Attendants (TBAs) or dais, have been integral part of rural India for centuries and in most other developing countries these are similar histories relating to traditional cultural patterns of childbirth. PHC interventions initiated a new interest and concern in incorporating the skills and contacts of the TBAs into modern health service delivery as a means of reducing maternal mortality. Training programmes were designed, kits were provided and support and supervision by the nurses and auxiliaries planned.

The numbers of trained TBAs are hard to estimate, but TBA and dai training programmes are now organised in 82 per cent of developing countries, compared to 37 per cent a decade earlier (Royston and Armstrong 1989). In India (where three quarters of all births are estimated to be attended by dais) 580,000 had received a one month training (Somjee 1991).

There has been considerable scepticism about these training programmes, where reports have shown the effects of the training programmes on maternity outcomes to have been negligible. Relevant factors include scepticism from the trained health workers, leading to failure to provide supervision and support, together with poor training and failure to maintain the supply of kits and stipends (Royston and Armstrong 1989).

Furthermore the ambiguous status of the TBA has been reported to have had a negative effect on the programmes' viability. But recent studies have shown that the status of the dai is not immutable. It can be improved among other factors by training (Stephens 1990).

During the past 20 years, a deliberate attempt has been made to establish a new cadre of informal sector worker. CHWs usually receive a minimum amount of training and are expected to work as volunteers or for low pay. CHW programmes exist in most developing countries. The majority of CHWs are female. Walt reports, for example, that in 14 countries, 192,000 were female and 40,000 were male (Walt 1990).

Most informal sector workers receive little continuing training and are virtually unsupervised. They work within a weak community structure which means that there is little community or local control of, involvement or support for their activities. The economic crisis of the public health services has meant that they have increasingly come to rely on cash payments as a means of income.

2.4 The formal sector: nurses

Nurses form the largest single category of health workers in most developing countries and in most developing countries they are overwhelmingly female. To simplify the discussion, the article will focus on this cadre. There has been a rapid growth in the number of trained nurses in developing countries (Table 1). In some cases there was a four-fold or greater increase between 1964 and 1985. There has been a significant fall in the average population per nurse in many countries. The fall in the ratio of physicians to nurses demonstrates the success of the policy of concentrating training on middle-level cadres.

In spite of the overall growth in numbers, serious shortages persist in the rural health services. Most nursing training is hospital-based and does not address the need for supervision, training and support of other front-line health workers. Some countries have begun

Table 1: Trends in total numbers of nurses, doctor/nurse ratios and population per nurse, in selected developing countries, 1965 and 1984

	Total nurses		Doctor/nurse ratio		Population/nurse	
Country	*1965*	*1984*	*1965*	*1984*	*1965*	*1984*
AFRICA						
Botswana	31	1,490	0.65	0.07	17,720	700
Ghana	2,099	19,403	0.27	0.04	3,730	640
Kenya	5,051	20,641	0.15	0.10	1,930	950
Zambia	621	9,126	0.51	0.10	5,820	740
AMERICAS						
Dominican Rep	2,321	5,183	0.96	0.69	1,640	1,210
Nicaragua	1,259	5,985	0.54	0.35	1,390	530
Paraguay	1,323	3,584	0.84	0.68	1,550	1,000
ASIA						
Bangladesh	..	10,976	..	1.33	..	8,980
India	76,178	443,011	1.33	0.67	6,500	1,700
Sri Lanka	3,478	12,287	0.55	0.23	3,210	1,290
Thailand	6,104	71,306	0.69	0.11	5,020	710

Note: Data on health care staff is estimated from World Bank Data on Population per physician/nursing person (World Development Report 1988 and 1991) as well as from United Nations' data on population (UN, 1989, World Population Prospects 1988).

Data may not always be comparable between countries, as the definition of nurse may differ. However, data reflect general trends.

to change nursing curricula to accommodate the PHC approach. Others have faced constraints including traditional values in nursing education, nursing practice and legislation regarding nurses registration and licensing. Little has changed in nursing education or task description to accommodate new approaches. Nurses continue to be trained primarily for hospital work (Pizurki et al 1987). This had led to a situation where no-one is explicitly being trained to provide basic services to the population or to provide supervision and management support to that cadre.

Nursing is segmented into a number of hierarchical levels, e.g. professional nurses, (often university trained), non-professional (two to three years training) and auxiliary nurses (semi-skilled). In addition, a small proportion of the professional nurses may rise to senior management level. However, the training of the different cadres, their levels of responsibility and the mobility between levels differs a great deal. There are no commonly agreed guidelines on the appropriate organisation of nursing work in developing countries. The definition of the relative roles of these different categories of worker is often an arena of intense struggle.

The structure of the nursing profession in many countries reflects their colonial heritage. Brian Abel Smith describes how upper and middle class women used the nursing profession to create a power base for women and struggled for the upgrading of the hospital services in nineteenth century Britain (Abel-Smith 1960). The result was a nursing profession which was dominated by a small number of professional leaders and in which most of the work was carried out by nursing aids and practical nurses who were recruited from the working class and received little theoretical training. This pattern has been reproduced in the very unequal societies of Africa and Asia.

In recent years, the financial constraints in the public sector have led to a slow down in the number of new jobs and a fall in wage levels. Attention of human resource planners in the health sector is shifting from a simple concern with numbers to improving the effectiveness of the existing corps of health workers. There is likely to be a major re-definition of the structure of the health sector workforce over the next

few years which will elicit a reaction by the organised professions. The politics of gender will play an important role in this process, and the next section of the article addresses three areas that will need further research.

3 PROFESSIONALISM, DECISION MAKING AND VIABLE ECONOMIC LIVELIHOODS IN THE HEALTH SECTOR

The changes in the roles of women as providers of health care have been affected, as discussed earlier in the paper by the adoption of the PHC approach and by the economic crisis. This section raises questions in regard to three key issues that need to be addressed in relation to women's changing roles; professionalism and the implications of changes for women's work and status; decision making patterns and thirdly the erosion of viable livelihoods for many women at the bottom end of the health sector hierarchy.

3.1 Professionalism and gender

This section looks at the impact of the role of the health professions in legitimising gender differences between different categories of workers, whereby women in the health sector predominate in jobs with low status and low pay.

Earlier theoretical work on the function of the medical profession described candidate selection, the long socialisation processes, the reward structure and postgraduate opportunities, registering and licensing procedures all of which were established and controlled by the profession itself (Freidson 1972). Parry described the conscious exclusion of women from the medical profession and their fight to gain entry, as well as the fight of the nurses to have their profession recognised as distinct from lesser trained or untrained lay healers (Parry 1976).

Going beyond a functionalist analysis of maintenance of professional and ethical standards, Navarro and Ehrenreich describe the role that medicine and the profession play in capitalist society in supportung class, race and gender divisions, including looking at the social control function of medicine (Navarro 1976 and Ehrenreich 1978).

These critiques of the medical profession were accompanied by feminist critiques which described the history of the medical profession from a woman's perspective. These tended to show how the medical profession had become institutionalised as a male upper class monopoly occupation, leaving outside its boundaries the midwives, nurses and lay healers. This exclusion has no consistent justification, but the stereotypes of 'innate feminine nature' were established to justify female subservience in the medical system (Ehrenriech and English 1973).

Fee argued that the medical profession conforms to the patriarchal pattern established in the family and that the solution is not simply to increase the number of female doctors, since paternalism and authoritarianism in medicine are structurally and culturally determined. She advocates enhanced power to patients and women and self-help groups where medical knowledge can be demystified and alienation between the health system and women lessed (Fee 1975).

The history of the medical and nursing professions in developing countries show similarities to the models of professions that developed in Europe at the turn of the century. Both professions developed with a determination to maintain standards that were internationally accepted and to maintain links with international professional organisations. Medicine in most developing countries also became a high status, predominantly male occupation with correspondingly high salaries. Nursing was more difficult to export as an attractive or high status occupation for girls, particularly in Asian countries, and nursing schools had great difficulty in attracting candidates.

In Africa, nursing at first attracted only male applicants. In East Africa the problem of attracting females into the nursing profession was a direct result of the comparative lack of education for girls, where boys alone had the necessary school leaving qualifications. To ensure the development of a female nursing profession, the entrance requirements for girls were lowered until sufficient girls had been trained (Raikes 1975).

While medicine retained its high status and led to the over production of doctors in many countries, nursing gradually achieved a higher status as families of girls in India and Bangladesh, for example, perceived the advantage of training a daughter and attracting a doctor husband. Nursing became a major channel for upward mobility for girls, after teaching, although still in many countries there is a shortfall in the numbers trained.

Amongst the nurses there have remained wide professional differences with girls from better off families and more years of schooling receiving one training, and girls with less education receiving a lesser training, remuneration and status. However in many developing countries the nursing profession has tended to be far less subservient to the medical hierarchy, rather taking it as a model for professional status and advancement. Strikes, for example, for pay increases by doctors in some countries have been followed by strikes by nurses for similar pay increases.

On the positive side, nursing legislation and nursing training controlled by the nursing profession, has been able to establish and maintain high standards of

hospital care for curative medicine in some hospital settings. In the face of the cuts and the problems that many health sectors face, the profession of nursing has often retained an impressive degree of accountability and a moral code of behaviour under extremely difficult circumstances that could otherwise have been more easily eroded (Holden 1991).

However the blanket acceptance of established attitudes and codes of behaviour also limits the nurses role. For example, Rispel and Schneider argue that professionalism in South Africa discourages nurses from confronting their social responsibility, where for many years nurses have been able to work without confronting the question of apartheid, its implications for their work and the wide disparities in the health status of the different populations (Rispel and Schneider 1991).

The issue of professionalism has resurfaced in developing countries as a central issue in the PHC debate, where on the one hand, community participation is seen as the key to demystifying and engaging people in defining their own health care needs and in producing services (Chambers 1991). On the other hand the serious breakdown of norms and regulations governing the practice of medicine and the distribution of drugs, is considered a serious threat to health for whole populations. For this reason Leonard argues that strengthening professions is the most feasible way of re-introducing quality controls and stopping the deregulation of drugs and procedures (Leonard 1991).

These two views express a range of problems that were raised in the earlier literature but perhaps appear more acute and complex given the stage of development of the health sector labour force, the crisis and the solutions being proposed, as well as the deep concern over the deregulation of drugs and procedures. Moreover a re-thinking of the role of professions in the delivery of health care is likely to have a far more profound impact on women's work in the health sector, where they tend to occupy the low paid, semi-skilled jobs.

3.2 Gender relations, planning and decision making patterns in the health sector

PHC policies have also provoked a new discussion on decision making patterns in the health sector, advocating that communities and all members of health teams should be involved in the decision making process. But not only have decision making processes hitherto been hierarchical and non-participatory; they have also been gender biased, with women in the majority of cases, having been excluded from major roles.

The marked hierarchical structure of the health sector and its gender inequalities reflect gender inequalities found in other sectors and in society at large. While the bulk of health care is provided by women, their participation in planning and management processes has been limited owing to fewer opportunities in training, gaining access to information, education and opportunities than men (Pizurki et al 1985).

Gender stereotyping in medicine, with a great preponderance of male physicians, is still apparent in most countries today. This pattern reflects the income and status differentials that are attached to medicine in contrast to nursing and auxiliary health care work, where the ratio is reversed and women predominate. Male domination in the health sector in relation to decision making processes is reinforced through professional ethics, socialisation during training, preferential access to resources including salary differentials, as well as to sexual power.

Many countries, recognising the error of the sexual imbalance in the male/female doctor ratio and the need for female doctors, have established positive discrimination policies for entrance to medical schools with the result that there is now an increasingly high proportion of female entrants into medical school, which for 1984-85 enrolments was 35 per cent on a world-wide basis. In another sample of 32 countries 39.4 per cent of physicians were female in the early 1970s[2].

However despite an increased female intake, gender differences within the medical profession persist, with assumptions about female specialization, with data from a number of countries showing a higher percentage of female doctors in paediatrics contrasted to the minority of females who specialize in surgery. Related to female opportunities in specialist fields are decision making opportunities in the formal health system. While no data is available for developing countries, data from Europe, the USA and Russia shows that where there are more female physicians overall so are there more females in decision-making positions. However, when managerial positions are examined and the number of women in top ministry positions and as heads of departments are counted, the number of females in negligible.

This statistical approach to the collection of data on women in medicine indicates a trend but does not describe the dynamics of gender relations, based on the sexual division of labour within medicine, where in every group practice, in each department and on every committee the likelihood of women taking leadership roles in decision making is minimal. However, even

[2] Figures in this section are taken from *Women as Providers of Health Care*, WHO, Geneva, 1987.

when women are in leadership roles in medicine, it does not necessarily follow that they will make gender sensitive decisions in relation to either PHC or women's health issues. Without more data, and particularly qualitative research material, it is difficult to see what role women in medicine do play when they are in leadership positions. There are few indications of how this would work.

> One example of female physicians' positive role in PHC leadership and management is the Women's Health Coalition in Bangladesh, where a gender approach to women's health has led to the provision of a holistic service for women's health care needs that now runs 19 Well Women Clinics (Women's Health Coalition, Bangladesh, 1989).

In relation to the relative strengths and weaknesses of medical and nursing professions and decision making, there are examples of the countries where the nursing profession does appear on an equal footing at ministerial and planning levels. For example it would seem that nurses are centrally involved in management and decision making processes in Botswana where the trained nurses are 98 per cent female and hugely outnumber the medical doctors. Foreign doctors have been employed to fill the vacant medical posts, but they cannot fill the void at the decision making levels of medically qualified nationals. This gap has been filled by highly competent and professional nurses, who have fought for the preservation and advancement of nurses status and position. But there is no indication that there has been any willingness on the part of the nurses to involve women in the planning and provision of any aspect of maternal and child health and family planning (Ngcongco 1989).

Where there are cases of female influenced decision making processes, this usually happens when elements of power have come within the grasp of a small and elite group of better qualified nursing professionals, generally leaving the majority of female nursing workers as vulnerable (weak) as before in relation to males in (and out of) the medical profession. Female nurses are often oppressed by the domination of the medical profession both psychologically and physically, reflecting a similar vulnerability of women in other formal and informal sector occupations and in the wider society (Pizurki et al 1987). Reports of sexual harassment, payments demanded from female health workers both in cash and kind for their admission to training schools, for the postings and for promotion have been made from female health workers at all levels.

> For example Mary, a Family Health Field Educator in Kenya, was offered a place on the training programme if she offered sex to a member of the District Health Team who was responsible for selecting the District candidates. Since her training and posting she has had to regularly satisfy this man in order to keep her posting.
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> Eunice, an experienced graduate nurse, working in the AIDS programme for an international NGO was sexually harassed by both her national counterpart and one of the donor experts and then raped. A separated mother with three children to support she found her original complaints led to potential dismissal. She has now withdrawn her case.
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> In Madhaya Pradesh in a survey done in 60 villages problems with recruiting, posting and keeping the female Multipurpose Workers in the Rural Sub-Centres were reported as lack of physical security where these health workers were continually subjected to verbal and physical attacks by male villagers until they were authorized to leave their health posts and find accommodation with families in the village.

Sexual harassment, violence against women, and rape are everyday phenomena in many parts of the Third World. Increasingly, research is showing how common this pattern is (Toft 1986; Levinson 1989; Raikes 1990; Hillmore 1991).

For health workers the question must be how to guarantee the safety of all female health workers and, at the same time, how to ensure that the health sector recognises violence as a health issue for women that needs to be addressed urgently both with active support and health education programmes. These issues are central to the inequalities found between male and female health workers and need to be addressed as a central part of the biases in decision making processes in the health sector.

3.3 Female health workers and erosion of viable economic survival strategies

In the past doctors have had an advantage over nursing and other female health workers in relation to income supplements, in that their control over diagnostic skills, drug prescribing combined with their comparative freedom from domestic obligations, meant they had both time and resources to organise private practice to augment their salaries. Private practice for doctors in many countries has been legal and where it has been illegal, there were often ways round the system that were acceptable to interested parties.

Nurses and other female auxiliary workers had more limited access to resources and so less means of augmenting their lower salaries. This was partly because their skills were different, but also related to professional norms and legal boundaries which

prevented them from diagnosing, treating and prescribing without the authority of a doctor.

There are now indications that this pattern is breaking down, and that there is a constant movement of health workers, particularly nurses and female auxiliary health workers, between government employment, NGOs, private sector and informal sector work. Nurses in Kenya for example have been recorded as setting up in private practice and prescribing, something previously unknown but still illegal[3]. Nurses in Uganda now moonlight and offer private practice, selling drugs within the public health services or privately as a matter of course, where these survival strategies are now referred to as 'magendo' and discussed openly (Holden 1991). Nurses in Bangladesh, who used to lobby for increased housing benefits, transport, school allowances for their children and better working conditions and wages within the public sector, have more recently opted to move either to private sector employment or migrate for better working conditions (Somjee 1991; Robson 1990).

While the better qualified nurses appear to have found ways of coping with their reduced incomes, what can be said of the auxiliaries and the CHWs? Have they too found other ways of supplementing their health sector stipends or have they now become members of the 'new poor' those who had their foot on the ladder and have now become dislodged? (Moser 1991.)

Given the combined high level of demand for minimal training schemes like those of the TBAs and CHWs, it is likely that training still leads to income generating possibilities where none existed before and that health workers are not part of the 'new poor'. What is more likely is that increasing fees for services are now a regular feature of rural health care work, even in situations where the services are supposed to be provided free or provided at a fixed cost.

An example of this is the distortion caused by incentive payments to both clients and motivators (minimally trained female health workers) for family planning acceptance in both Bangladesh and India. The system was designed to promote the up-take of the family planning programme, but the incentive payments and the imposition of government targets to all health workers has distorted its operation (Sundaram 1989; Hartmann and Standing 1989). Reports show that half of the money paid to the clients is often kept by the health care motivators who regard it as their right to charge the patient for their service. So this extra cash has now become an essential part of the survival strategies of the various categories of rural health workers, and an extra cost of survival to the rural population.

The movement of health workers between government, NGO and private care as well as the movement into informal sector work, has led to a deregulaton of services and a resulting lack of accountability. These changes will affect both the efficacy of treatment and the role of prevention as well as representing a further impoverishment to those who are already worse off.

Minimally paid health workers, although marginally better off than the poor, need further resourcing as one of the ways of reducing the chaos that exists at present in many health sectors. In addition to regular salaries, resources for minimally paid health workers can be improved by supplying creches for the children of female health workers, food supplements for female workers and their children as well as ensuring that their stipends, travel allowances and supplies are maintained. The issue of the resourcing of all community workers and volunteers is crucial. CHW programmes have suffered from sex-role stereotyping, based on an assumption of the availability of female volunteers and free or cheap labour. This assumption, concerning women's labour time, has proved false where women's labour is not in surplus and moreover women are overburdened by their roles in production, reproduction and the cuts in services.

However, where CHW programmes are assessed to have been poorly planned and to offer no indications of improved health care activities in villages, training and resourcing, the role of this cadre will need re-thinking. Minimally trained CHWs should not be abandoned to seek out a living in the informal sector accelerating the deregulation of drugs, but instead could perhaps be redeployed in creches, feeding schemes or in hospices for AIDS victims.

4 CONCLUDING REMARKS

This article does not take the stand that health services are the only way, or indeed the main way, to improve the health status of people in developing countries. Improved health status for women and whole populations will come about with improvements in access to resources, to improvements in nutrition, sanitation and water.

However within this framework health services and PHC in particular still has a vital and viable role. The PHC approach needs health workers to be highly motivated, capable of adapting their work tasks, time and energies to handle constantly changing new demands. For this they should not just be appropriately trained and supervised but also they must be adequately resourced.

[3] Communication from Karanja Mbugua.

The (re)-establishment of a cadre of effective health workers is one of the highest priorities for many developing countries. This provides an opportunity (or threat of) substantial restructuring of the workforce. Questions such as the relative responsibilities of different cadres, pay and career structures, relationships of authority, relative roles of the private and public sectors, and the role of professionalism and professional bodies will be increasingly important in years to come. The politics of gender is likely to play an important role in this process.

There are a number of research questions that would appear to be crucial in relation to some of the issues raised in the article:

In relation to professional structures:

- What role do the professions play in PHC and what will be their role in the restructuring of the health sector workforce?
- To what extent can the nursing profession specifically play a progressive role in the restructuring process for PHC?
- How can communities and individuals be supported to define their own health needs and to organise themselves to produce and pay for services within the existing framework of rigid professional health sector and gender biased hierarchies?

In relation to informal sector health workers:

- Where programmes have been appropriately defined and appear functional, how can they be sustained and adequately resourced?
- At what level is control and regulation over access and distribution to pharmaceuticals appropriate?
- Where existing informal sector and minimally trained formal sector health workers are assessed to be inappropriate, what alternatives can be found that will maintain a health related role for these cadres?

In relation to the restructuring of the workforce:

- How should career structures be restructured and who should supervise whom?
- Should the sharp distinctions between categories of health workers be maintained or should mobility between levels be encouraged?
- What role do gender hierarchies and gender biased decision making have on the production of health care services in developing countries at all levels?

In relation to women as major producers of health care:

- What are the special needs of female health workers at all levels in relation to child care, working hours, security and allowances?
- To what degree does security and sexual harassment intimidate and limit the work of female health workers and how can this be addressed?
- Where are there possible links in relation to a gender alliance between the female health workers and their female clients over women's health issues?

This article argues that the role of gender in the restructuring process as a basis for a future alliance for health needs to be addressed. Gender roles need to be discussed more openly between the health teams, planners and health workers at all levels in the health sector, so that problems can be identified. Discussions concerning changes that can be made in gender roles that are related to patterns of authority, power and decision making in health sector planning (leaving women as the main providers of PHC, without participation in planning mechanisms) are needed as a crucial part of any restructuring process.

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