Rachel Tolhurst Publications


*Health care financing reforms in both China and Vietnam have resulted in greater financial difficulties in accessing health care, especially for the rural poor. Both countries have been developing rural health insurance for decades. This study aims to evaluate and compare equity in access to health care in rural health insurance system in the two countries.*


*To examine changes and equity in use of maternal care in different types of rural and urban areas in China from the early 1990s to early 2000s data were drawn from three National Health Household Interview Surveys conducted in 1993, 1998, and 2003. There were large disparities in use of maternal care between urban and rural areas and among different sized cities and rural areas with different levels of socio-economic development. But the disparities narrowed over time, especially among different types of rural areas. Maternal care utilization made remarkable progress in the study period, and the gap between rural and urban areas and among different classes of cities and rural areas significantly narrowed. This was probably due to both socio-economic development and targeted investments in improving health services. However, significant gaps remained, requiring attention.*


*In China, the New Co-operative Medical System (NCMS), a rural health insurance system, has expanded nationwide since 2003. This study aims to describe prenatal care use, content and costs of care in one county where prenatal care is included in the NCMS and two counties where it is not. It also explores the perceptions of stakeholders of the prenatal care benefit package in order to understand the strengths and weaknesses of the approach in the context of rural China and to draw lessons from early implementation. Whether or not prenatal care was included in the NCMS, prenatal care use was high, but the contents of care were not provided following the national guideline and more expensive tests were recommended by doctors. Costs were substantial for the poor.*

Rachel Tolhurst, Yaa Peprah Amekudzi, Frank K. Nyonator, S. Bertel Squire, Sally Theobald. “He will ask why the child gets sick so often”: The gendered dynamics of intra-household bargaining over

This paper explores the gendered dynamics of intra-household bargaining around treatment seeking for children with fever revealed through two qualitative research studies in the Volta Region of Ghana, and discusses the influence of different gender and health discourses on the likely policy implications drawn from such findings. Most studies that have considered gender in relation to malaria have done so within a narrow biomedical approach to health that focuses only on the outcomes of gender relations in terms of the (non-)utilisation of allopathic healthcare. However, we argue that a ‘gender transformatory’ approach, which aims to promote women’s empowerment, needs to include but go beyond this model, to consider broader potential outcomes of intra-household bargaining for women’s and men’s interests, including their livelihoods and ‘bargaining positions’.


Critiques of gender mainstreaming (GM) as the officially agreed strategy to promote gender equity in health internationally have reached a critical mass. There has been a notable lack of dialogue between gender advocates in the global north and south, from policy and practice, governments and non-governmental organisations (NGOs). This paper contributes to the debate on the shape of future action for gender equity in health, by uniquely bringing together the voices of disparate actors, first heard in a series of four seminars held during 2008 and 2009, involving almost 200 participants from 15 different country contexts. Focussing on key discussions around sexualities and (dis)ability and their interactions with gender, we explore issues around intersectionality across the five key themes for research and action identified by participants: 1) Addressing the disconnect between gender mainstreaming praxis and contemporary feminist theory; 2) Developing appropriate analysis methodologies; 3) Developing a coherent theory of change; 4) Seeking resolution to the dilemmas and uncertainties around the ‘place’ of men and boys in GM as a feminist project; and 5) Developing a politics of intersectionality. We conclude that there needs to be a coherent and inclusive strategic direction to improve policy and practice for promoting gender equity in health which requires the full and equal participation of practitioners and policy makers working alongside their academic partners.