Gender Blind:

Rebuilding Health Systems in Conflict-Affected States - Northern Uganda

Gender equality: Northern Uganda has suffered cycles of intense violence since 1986, leaving many dead and internally displaced persons (IDPs). A number of community women’s groups were involved in peace processes long before the Juba peace agreement took place in 2006 between the Ugandan government and the Lord’s Resistance Army (LRA). Nevertheless, women had to push to be included in peace talks. Literacy rates in northern Uganda are a sign of gender inequality, with literacy among men at 60% compared to just 40% among women in 2002.

Health equity: There is a lack of up-to-date information on the causes of death and disability in northern Uganda. During the war, women experienced high levels of sexual violence; young men were not exempt. Even in the “protected” camps, sexual violence was rife. Indications are that fertility rates increased after the war. Women who survived the conflict suffered primarily from gynaecological and maternal health problems and HIV/AIDS. Sexual and reproductive health services are clearly required.

Impact of conflict on gender roles: Women and children bore the brunt of conflict. Children were forced to commit atrocities against their own families, and girls were used for sex by the LRA, many giving birth at a young age. These young mothers were in need of particular help in settling back in their communities. In camps, gender roles were affected by the loss of farms. While women’s domestic roles remained much the same, men’s roles as the breadwinner changed as families relied on humanitarian aid which was often aimed at women. More households were led by women and widows. This loss of men’s power often led to frustration - expressed through domestic violence, separation and women’s heightened vulnerability to rape, unwanted pregnancy and STIs.

This case study on northern Uganda is part of the Building Back Better research initiative undertaken by the Stockholm International Peace Research Institute (SIPRI) working group on gender and the ReBUILD consortium. The team conducted four case studies of countries affected by conflict - Mozambique, Timor Leste, Sierra Leone and northern Uganda - to examine whether health system reconstruction has promoted equality and created a health system that is gender equitable.
INTERNATIONAL HEALTH ENGAGEMENT AND GENDER

Humanitarian: In 2008, IDPs started to move from the protected camps to satellite camps. The UN appealed for support for basic services such as water, sanitation, health and education.

Health system: The health system in Uganda is decentralised, with districts responsible for the delivery of health care. Although user fees were abolished in 2001, in practice essential drugs are unavailable in health facilities, and the better off pay for services from the private sector.

General gender programming: The government’s reconstruction and reform plan did not include gender equity as an objective, and gender mainstreaming is a key guiding principle only. The Ministry of Gender’s involvement in reconstruction was constrained by limited human and financial resources. Government policies may call for the mainstreaming of gender in policies and programmes but monitoring implementation, especially in northern Uganda, is a challenge.

IS THE HEALTH SYSTEM IN UGANDA GENDER EQUITABLE?

The health system was measured against WHO’s six health system building blocks:

Health service delivery: Reproductive health indicators in general were poor which suggests a lack of equitable and free access to services. In IDP camps the total fertility rate was high at 8.6, compared to 6.7 nationally. The contraceptive prevalence rate in northern Uganda was much lower than nationally and just 30% of babies were delivered in a health facility. An analysis of research by ReBUILD in Gulu district found that post-conflict health reform focused too much on the reconstruction of health facilities, and maternal and child health.

Health workforce: The number of health workers in post-conflict districts of northern Uganda is very low. Staff data is not broken down by sex or role. Research shows that human resource planning is “gender blind” and the specific needs and challenges of the predominantly female health workers in Gulu district are not considered, curtailing training and promotion opportunities.

Health information systems: are weak and no data is available, broken down by sex, on the leading causes of death. There is a lack of data to measure equitable and free access to health services.

Health system financing: ReBUILD’s analysis shows that even people who went to government hospitals in northern Uganda were obliged to pay for supplementary medicine from private facilities, as in the rest of the country. This raises concerns about gender equity, notably the financial barriers facing women in accessing health care, especially the elderly and widows.

Medical products and technologies: Gender equity has not been considered in pharmaceuticals and medical technology, apart from specific treatment of obstetric care.

Leadership and governance: although the Local Government Act guarantees one third female representation on the district councils, it fails to address gender in leadership in health reform.

Northern Uganda urgently needs a post-conflict recovery plan which is sensitive to gender concerns. What little has been done for the survivors of gender-based violence has not been linked to overall health systems strengthening: this constitutes a missed opportunity. Rebuilding hospitals - although essential - does not in itself lead to increased use of health services, especially if the ability of the poorest to pay is overlooked. Gender equitable financing mechanisms are key to ensure that those most in need are not left behind. Providing maternal and child health services is vital, however, use of health services goes beyond this limited approach. Action is also needed to consider the health workforce from a gender perspective. This is key in order to support health workers in post-conflict contexts to reach their potential and fulfil their roles in delivering health care to women and men.

ABOUT THIS BRIEF
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