Gender Blind:
Rebuilding Health Systems in Conflict-Affected States - Sierra Leone

This case study on Sierra Leone 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.

CONTEXT AND CONFLICT

Gender equality: Sierra Leone is almost bottom in the Human Development Index, ranking 180th out of 187 countries. There is significant gender inequality: a mere 23% of women are literate, half the rate among men. Domestic violence is widespread. Despite adoption of the Domestic Violence Act and other “gender bills” in 2007, as well as a national gender-based violence action plan, enforcing the law is a challenge due to a lack of financial and human resources and the influence of “customary law”. Customary laws discriminate against women and girls, granting men rights over the land and resources and perpetuating violence within marriage. Women make up just 13% of parliamentarians but do, however, play a key role as heads of national and international NGOs.

Health equity: Infectious diseases such as malaria, TB and HIV/AIDS are the leading causes of deaths and illness. In spite of improvement in women’s and children’s access to services, the under-five mortality rate is the highest in the world. The maternal mortality ratio - at 857 per 100,000 live births - is one of the highest in Africa, due to a shortage of health workers and obstetric equipment, low use of modern contraception (just 21% of women), and unsafe abortion. A survey in 2008 found that only one in four women gave birth in a health facility. The vast majority of women have suffered FGM.

Impact of conflict on gender roles: The conflict in Sierra Leone, which began in 1991 and did not end until 2002, left two million displaced, up to 20,000 dead and 7,000 amputees. Civilians suffered extreme violence; men and women were victims of sexual violence. Forced to have sex in camps, girls were at increased risk of STIs and unsafe abortion, as well as trauma. Gender roles changed during the conflict as women assumed more responsibility, in the absence of men. Although key legislation to address gender inequality was adopted in the post-conflict period, in part due to the efforts of the women’s movement, advances in the status of women were modest and widespread acceptance of customary law remains an obstacle.
Impact of Ebola on gender roles: The Ebola epidemic has had wide reaching impacts on the health sector, health workers and communities. Gender plays a part here too; women are more vulnerable to Ebola due to caring roles within the household; men on the other hand are more involved in burial rites, putting them also at risk. Women predominate amongst the lowest cadres of health workers who have been critical to the Ebola response – including volunteers, TBAs, Community Based Motivators and community health workers – and here again gender roles and norms shape vulnerability to Ebola. Ebola has meant that citizens are staying away from health centres, and rates of maternal death, as well as death from malaria etc have increased dramatically. The maternal mortality rate (MMR) is currently projected to be more than 2,000 per 100,000 live births in Sierra Leone, almost double that in 2013 (1,165 maternal deaths per 100,000 live births) returning MMR to pre-conflict levels.

INTERNATIONAL HEALTH ENGAGEMENT AND GENDER

Humanitarian: In the early stages of the humanitarian response, international NGOs addressed sexual violence by means of targeted, specific initiatives and through maternal and child health and sexual and reproductive health care. A 2002 report criticised the Government and the UN for failing to mount a cross-cutting approach to sexual violence. A number of Sierra Leonean women's groups advocated for gender equality; however, little effort was made to integrate their work into the humanitarian response. Some collaboration took place between international NGOs and the Government on gender issues but it is unclear whether health reforms incorporated the input of civil society.

Health system: The impact of conflict on the health system was substantial, and reforms took a long time to improve health. Several health reforms were undertaken, including decentralising health services between 2004 and 2008, and introducing user fees. The National Health Sector Strategic Plan (NHSSP, 2010-2015) aims to close gaps in inequality and enhance overall health, with a focus on maternal and child health and reproductive health. Despite government commitment to gender mainstreaming, no details are provided on how mainstreaming will be implemented.

General gender programming: Although women’s groups campaigned to be involved in peace delegations, no women took part in the Abidjan Peace Accord meeting in 1996, and only two women were involved in the Lomé Peace Accord which heralded the end of civil war. Few women hold senior positions in politics and most women in the judiciary are clerical staff with no decision-making powers.

Health information systems: The NHSSP states that “the effect of gender on health and health-seeking behaviour will continue to be defined through reviews and field studies so as to provide more information for appropriate policy development and resource allocation.”

Health system financing: Following the end of conflict, about 70% of health expenditure came from “out-of-pocket” expenditure, that is, households’ direct spending on health care. In recent years, the Government has introduced more equitable financing mechanisms, including providing free health care in 2010 to pregnant women, breastfeeding mothers and children under five.

Medical products and technologies: The NHSSP does not expand on gender equity in access to pharmaceuticals and medical technology. Nevertheless, it does refer to subsidised bed nets for children and pregnant women to prevent malaria, and a separate budget line for reproductive health and family planning products.

Leadership and governance: There is no mention in the NHSSP of gender equity in leadership positions in health reform or the need to include women in the governance of health systems.

HOW HAS THE PROPOSED EBOLA RECOVERY PLAN ADDRESSED GENDER?

The Government was criticised for its narrow approach to sexual violence immediately after the conflict. The most recent health strategy, the NHSSP, focuses on maternal and child health. Given the high rates of maternal and child mortality, this focus is necessary. The approach is nonetheless limiting. Women are framed as “vulnerable citizens” with little analysis of the social and cultural discrimination which leads to vulnerability in women and girls. While there is a section on gender, it appears to be an inconsistent addition. In addition the proposed Ebola recovery plan, follows the trajectory of not addressing the impact or ramifications of gender in health. Post conflict and post Ebola it does not seem that the Government has embraced a comprehensive approach to health reform which truly considers the health needs of women and men.

About this brief
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