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The Norman Paterson School of International Affairs

ReBUILD Consortium

Research for stronger health systems post conflict

Research in Gender and Ethics
Building stronger health systems

BUILDING BACK BETTER

Gender and post-conflict health systems

20th October 2015
The Foresight Centre, University of Liverpool

Join in & contribute:
#HSRFCAS #gender

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Research in Gender and Ethics (RinGs): Building stronger health systems

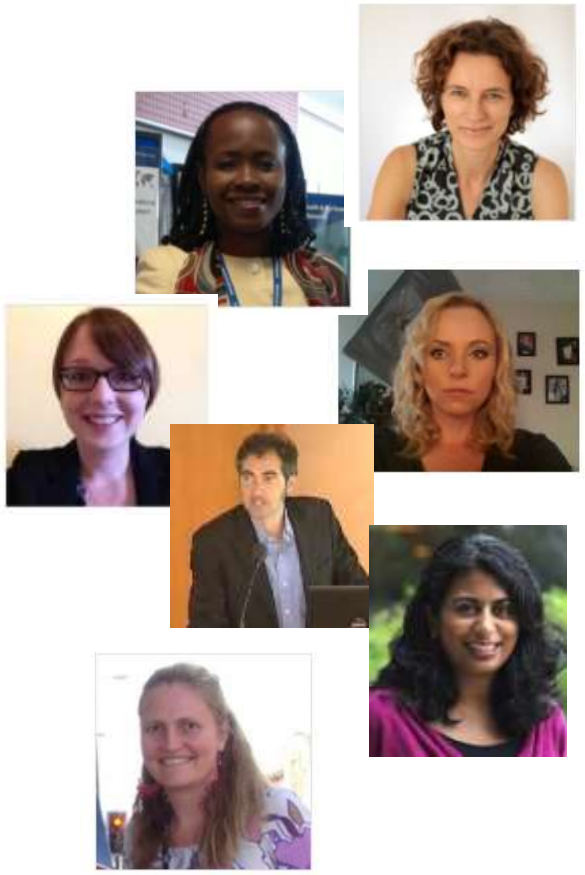
Who we are

Team Members

- RinGs brings together researchers and communications professionals from across

  the three Research Programme Consortia.

- Oversight of RinGs is provided by the Directors of the three Consortia.



Steering Committee

- Asha George, Johns Hopkins School of Public Health
- Kate Hawkins, Pamoja Communications
- Sassy Molyneux, KEMRI/ Wellcome Trust/ Oxford University
- Rosemary Morgan, RinGs/ Johns Hopkins School of Public Health
- Ravi Ram, AMREF
- Sarah Ssali, Makarere University
- Sally Theobald, Liverpool School of Tropical Medicine

What we aim to do

RinGs seeks to galvanise gender and ethics analysis in health systems by:

1. Synthesising existing research
2. Stimulating new research
3. Supporting a learning platform

Advances gender analysis through

1. Context-embedded approaches
2. Intersectionality
3. Ethical analysis of power relations and social exclusion

RinGs focuses on thematic areas common to all RPCs:

- care-seeking
- financing and contracting
- governance
- human resources in health

Future Health Systems
Innovations for equity

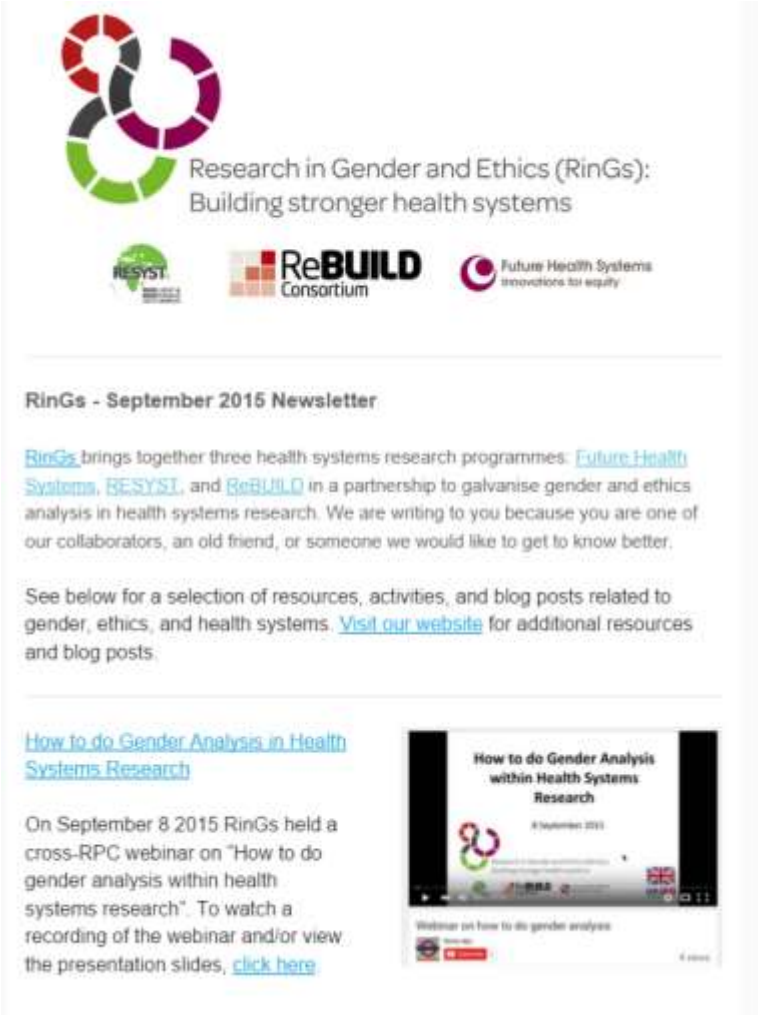
RESYST
RESILIENT & RESPONSIVE HEALTH SYSTEMS

ReBUILD Consortium

Newsletter

Sign up for our newsletter!

http://goo.gl/ieRTCw



Research in Gender and Ethics (RinGs): Building stronger health systems

RESYST · ReBUILD Consortium · Future Health Systems: innovations for equity

RinGs - September 2015 Newsletter

RinGs brings together three health systems research programmes: Future Health Systems, RESYST, and ReBUILD in a partnership to galvanise gender and ethics analysis in health systems research. We are writing to you because you are one of our collaborators, an old friend, or someone we would like to get to know better.

See below for a selection of resources, activities, and blog posts related to gender, ethics, and health systems. Visit our website for additional resources and blog posts.

How to do Gender Analysis in Health Systems Research

On September 8 2015 RinGs held a cross-RPC webinar on "How to do gender analysis within health systems research". To watch a recording of the webinar and/or view the presentation slides, click here

Contact us & stay in touch

E-mail: RinGs.RPC@gmail.com

Website: http://resyst.lshtm.ac.uk/rings

Twitter: @RinGsRPC

Google+: RinGs

Linked In:

https://www.linkedin.com/groups/Gender-Health-Health-Systems-Group-8293050/about

Photo Credit: bug_g_membracid

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The ReBUILD Research Programme Consortium

Research for stronger health systems post conflict

Tim Martineau

ReBUILD Co-Research Director

Liverpool School of Tropical Medicine

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Decisions made early post-conflict can steer the long term development of the health system

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ReBUILD: Research for Building pro-poor health systems during recovery from conflict

- **Countries & partners:** Sierra Leone (COMAHS), Cambodia (CDRI), Northern Uganda (MUSPH) & Zimbabwe (BRTI) + affiliates
- **UK partners:** Liverpool School of Tropical Medicine and Queen Margaret University, Edinburgh
- **Research:** Health systems strengthening in post-conflict settings
  - Health financing
  - Human resources for health
  - Gender/equity (including RinGs programme)
- **Theory of change** emphasises research uptake & capacity-building

HEALTH SYSTEMS IN FRAGILE AND CONFLICT AFFECTED STATES

This thematic working group draws upon the breadth of experience of key actors in health in fragile and conflict affected states and promotes research, policy and advocacy actions to contribute to the development and implementation of responsive and context-specific health systems.

Introduction

In September 2013, the Board of Health Systems Global approved the application from the Health and Fragile States Network (HFSN) and the ReBUILD consortium to establish a Thematic Working Group (TWG) that aimed to promote health systems research in fragile and conflict affected states (FCAS).

The group has been growing steadily and we are now approaching a membership of 400 on our LinkedIn site. Connecting us all up is already a major achievement. We are now working at making the group more interactive, thinking about the governance arrangements for the group, and encouraging members to engage through LinkedIn.

We have recently recruited 6 people who have demonstrated a strong interest in the work of the TWG to act as a resource for advice and help to the steering committee - Lara Ho, Ann Canavan, Fadi El-Jardali, Jason Nickerson, Khalifa Emulsharaf and Nigel Pearson. The advisory will further expand in the coming months.

Objectives of the TWG

1. Create or identify new knowledge through multi-disciplinary research on strengthening health systems in fragile and conflict affected states.
2. Foster research on the application of new knowledge in real world settings, i.e. implementation science.
3. Disseminate current and new knowledge.
4. Support knowledge translation through the engagement of relevant policy makers.
5. Further develop the TWG and associated network.
6. Contribute to the multidisciplinary health system research capacity of organisations and individuals located in FCAS.

Key activities of the TWG

Moving the research agenda forward

GROUP FACILITATORS

Steve Commins

STEERING COMMITTEE MEMBER

Suzanne Fustukian

STEERING COMMITTEE MEMBER

Tim Martineau

STEERING COMMITTEE MEMBER

Egbert Sondorp

STEERING COMMITTEE MEMBER

Jan Randles

SECRETARY TO THEMATIC WORKING GROUP

Building Back Better? An Overview

Valerie Percival
Norman Patterson School of International Affairs
Carleton University

Content

Background

The Issue

The Research

Moving Forward

Main Messages

- Gender equitable societies are more peaceful and prosperous;
- Health systems both reflect and shape their context;
- Health systems rebuilding is gender blind;
- Missed opportunity for change.

Background

SIPRI Initiative: 2012

Post-Conflict Health Reform

ReBUILD

Context


THIS IS NOT
A MESS,
IT'S AN
OPPORTUNITY!

CONTEXT

Women Peace and Security Agenda;

MDGs & SDGS;

In many places, rights for women and girls stagnant;

Silence on abuse of men and boys.

The Question

The Research

Stage One:

How gender sensitive is the reconstruction and reform of health systems in post-conflict countries?

What factors need to be taken into consideration to build a gender equitable health system?

Stage Two:

In selected case studies, did the rebuilding of health systems result in a gender equitable health system?

Stage One

- 2012-13
- Literature Reviews;
- Initial case study analysis.

Key Findings

Build it and it will be gender equitable: no guidance from health systems literature;

Gender responsive = address sexual violence; maternal health; maybe reproductive health;

No definition of a gender equitable health system;

No reflection on health system as an arena to build gender equity in society.

Gender Equitable Health System

Provides health care services that address the most urgent health care needs of men and women across the life span in an appropriate manner;

Ensures men and women across the life span are able to access and utilize those services unimpeded by social, geographic and financial barriers;

Gender Equitable Health System

Produces relevant, sex disaggregated health information that informs policy;

Ensures equitable health outcomes among women and men, and across age groups; and,

Provides equal opportunities for male and female health professionals working within the health system.

Stage Two

Case Studies: 2013/14

Challenges:

- **Case selection;**
- **Endogeneity and causality;**
- **How do we approach study?**

Approach

Assess impact of conflict on gender roles and norms;

Analyse post-conflict reform;

Apply def'n of gender equitable health system as a benchmark to assess health system;

Assess degree to which the health system meets benchmark.

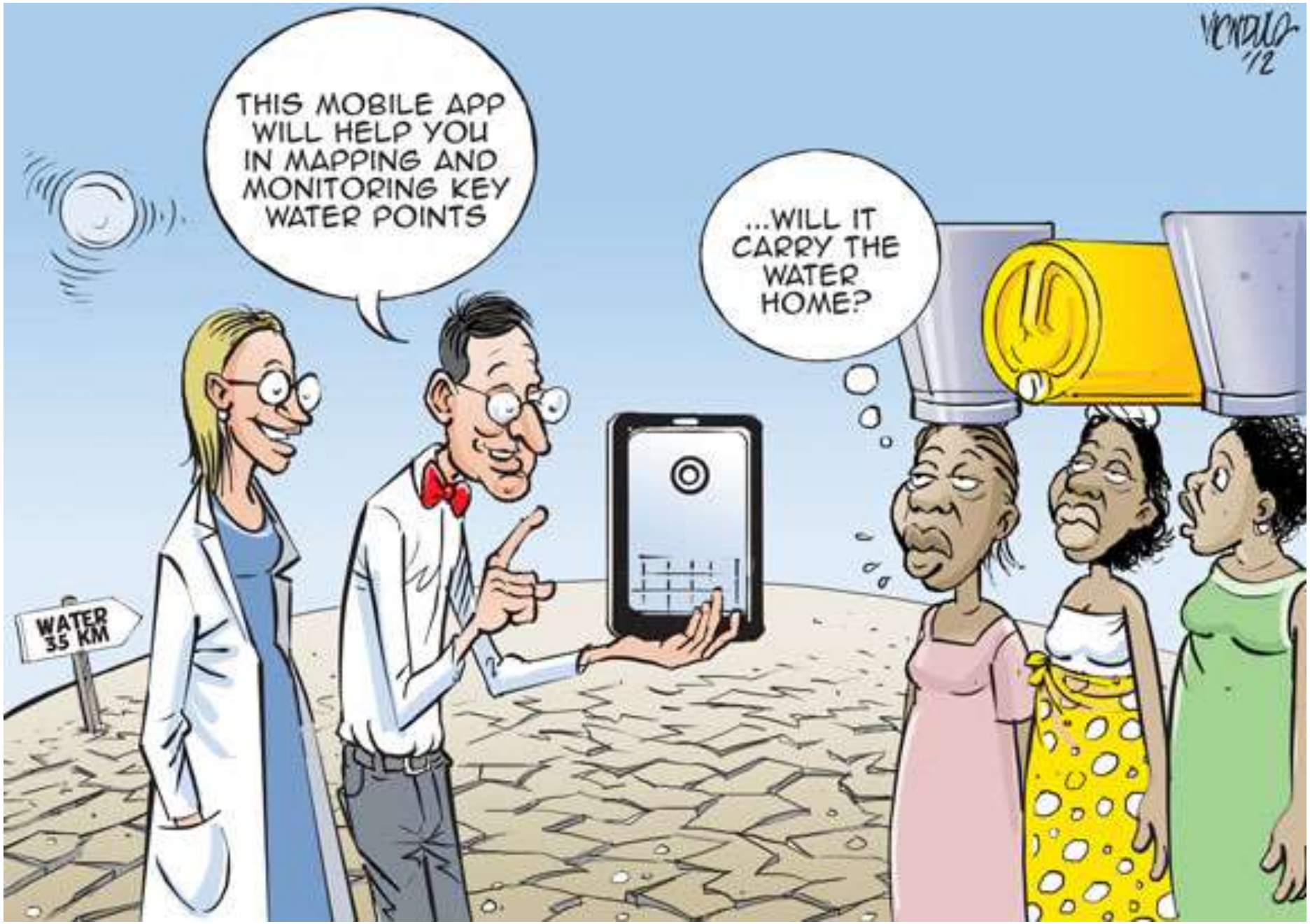
Key Findings: Gender Blind

Gender = addressing sexual violence, maternal health;

Most gender sensitive health reform effort – Mozambique – disappointing results;

Missed opportunity to utilize health system as tool for change;

Critical areas of intervention? Unclear.


THIS MOBILE APP WILL HELP YOU IN MAPPING AND MONITORING KEY WATER POINTS
...WILL IT CARRY THE WATER HOME?
WATER 35 KM

Politicizing Health System?

Key interface for women and men;

Address behaviours;

Key employer.

Why does this matter?

Building Back Better: resources

A new set of policy briefs

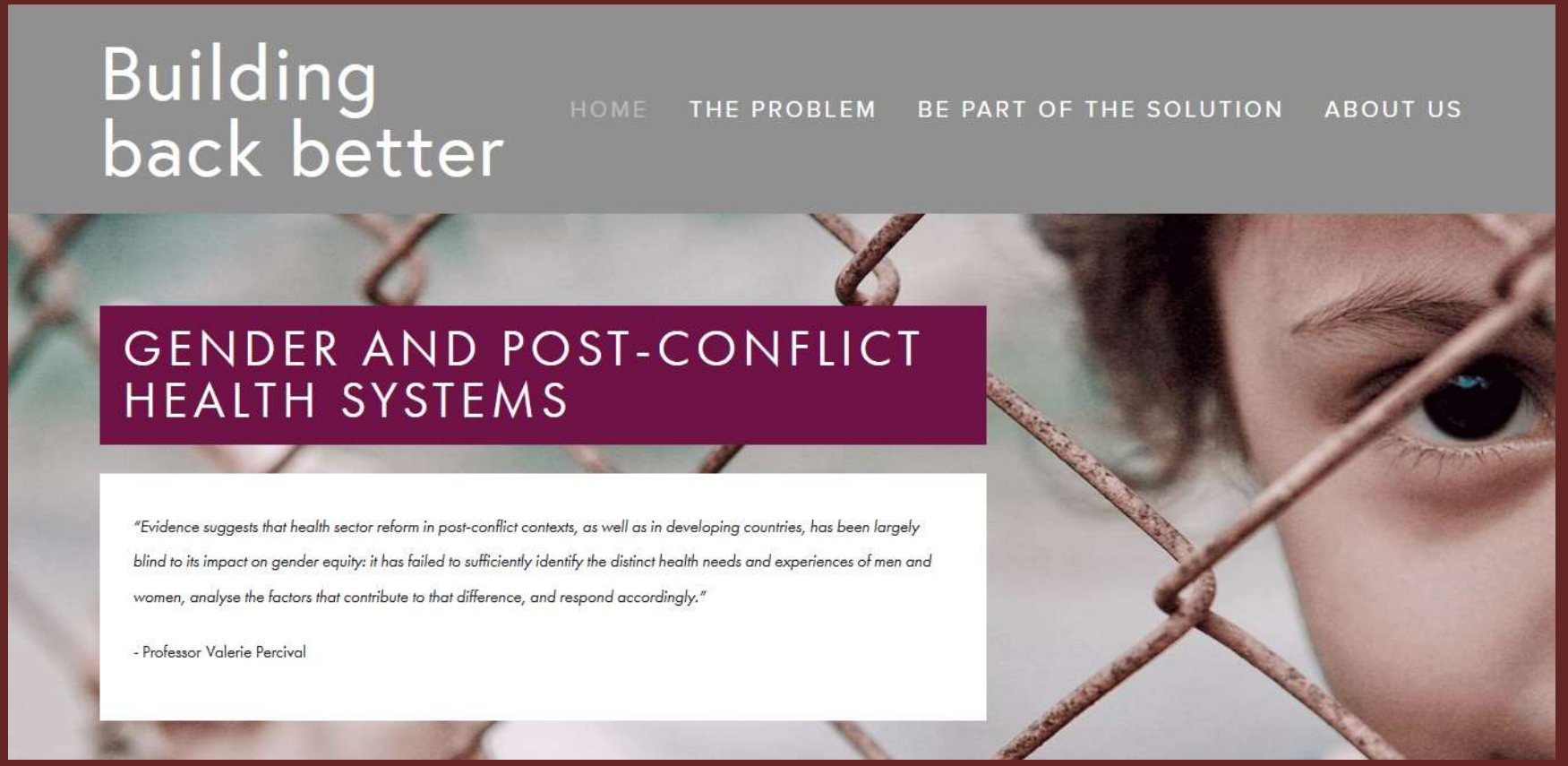
Gender in humanitarian responses and health systems strengthening

Including four country case studies

Building Back Better: resources

A new e-resource:

www.buildingbackbetter.org



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BUILD BACK BETTER

Perspective from Sierra Leone

Haja Ramatulai Wurie PhD
Research Coordinator and Research Uptake Officer
ReBUILD/COMAHS Sierra Leone

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ReBUILD Human Resource for Health Project in Sierra Leone – effect of conflict and crisis

- **Research aim:**
  - To understand the post-crisis dynamics for human resources for health and
  - Ultimately how to reach and maintain incentives to support access to affordable, appropriate and equitable health services.
- Gender and equity are mainstreamed
  - explore access to resources, roles, values, decision-making, and power
- Research was guided by the following questions.
  - How were gender considerations integrated within the efforts to rebuild health systems in post-conflict contexts?
  - What impact did the rebuilding of the health systems have on gender equity within the health system?

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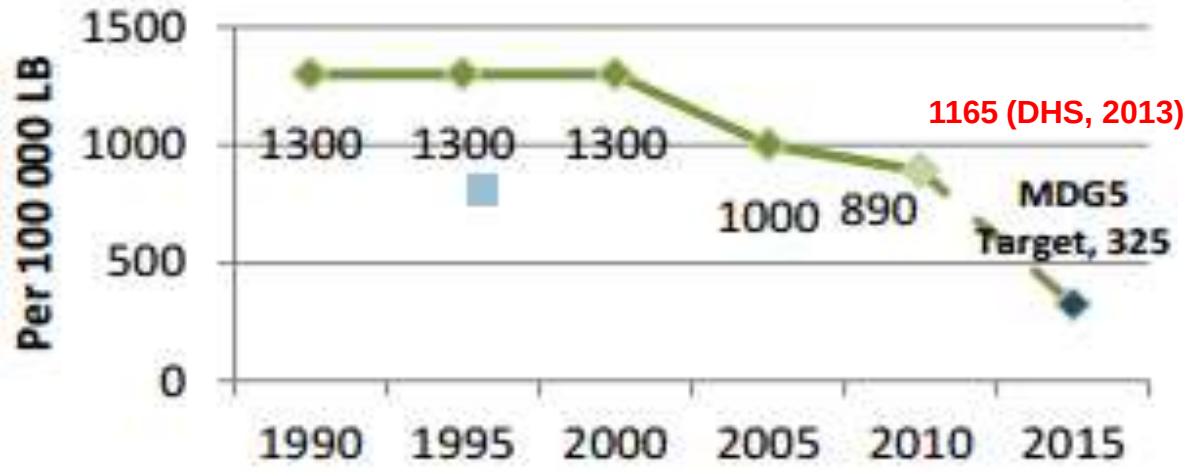
Maternal mortality ratio 1990 – 2008 and 2015 target



From WHO, Sierra Leone (http://www.who.int/maternal_child_adolescent/epidemiology/profiles/maternal/sle.pdf)

- The maternal mortality ratio - at 857 per 100,000 live births (2010) - one of the highest in Africa (same for under 5 mortality)
  - low use of modern contraception (just 21% of women), and unsafe abortion
  - 1 in 4 women gave birth in a health facility
- Free Health Care Initiative (FHCI)– Launched in 2010
    - However MMR reported in DHS 2013 was **1165 per 100,000** live births

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During Ebola

- Reduction in service utilisation
  - 23% reduction in the number of women who went to a health facility for delivery (Health Facility survey, UNICEF, 2014)
  - Increase in maternal deaths
  - 39% reduction in the number of children under-five treated for malaria during the period under review (Health Facility survey, UNICEF, 2014)
- Women 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.

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How were gender considerations integrated within the efforts to rebuild health systems in post-conflict contexts?

- National Health Sector Strategic Plan (2010 – 2015) stated goal
  - "to reduce inequalities and improve the health of the people, especially mothers and children, through strengthening national health systems to enhance health related outcomes and impact indicators."
- The WHO Country Cooperation Strategy (2008-2013) for Sierra Leone also makes references to their commitment to gender mainstreaming and the "human right to health and equity"
  - reduction of infant and child mortality and the promotion of reproductive and sexual health
  - However there are no specific implementation plans for how to address gender mainstreaming, beyond a mention that the WHO will work with the UN Gender Theme Group to support the implementation of the National Gender Strategic Plan in areas related to gender and health.

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Post Ebola Health sector recovery plan

- Conflict, like Ebola plays out along gender lines, and this is recognised in documentation
  - However does not seem to inform the response and rebuilding effort.
  - The Ministry of Social Welfare, Gender and Children's Affairs report on the multi-sector impact assessment of gender dimensions of the Ebola virus has not, for example, informed the Ebola recovery process and plan within the health sector

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What impact did the rebuilding of the health systems have on gender equity within the health system?

Attributes of Gender Equitable Health System	Manifestation in Sierra Leone
Provision: Health services addressing most urgent health care needs of men and women across life span in an appropriate manner.	FHCI has prioritized care for women and children, although there are limitations including Ebola. DFID provided support for SRH & child health – set back due to Ebola
Access: Ensure men and women across the life span are able to access and utilize services unimpeded by financial, social, geographic barriers;	FHCI removed financial barriers (nothing for men) • However ongoing challenges with it's effective implementation Ebola severely limited access to health • Gender roles and relations in remote parts meant that women are often unable to make decisions/have the financial and decision making autonomy to see care.
Relevant, sex-disaggregated health information that informs policy;	Not consistently available – clear focus in recovery plan – gender not currently a focus.
Equitable health outcomes among men and women and across age groups	Double challenge from conflict and Ebola, health indicators significantly worsened, MMR particularly challenging.
Equal opportunities for male and female health professionals working within the health system.	Male health workers given more opportunities e.g. international training – mostly men (IDI report). Female health workers training more often within the W. Africa region.

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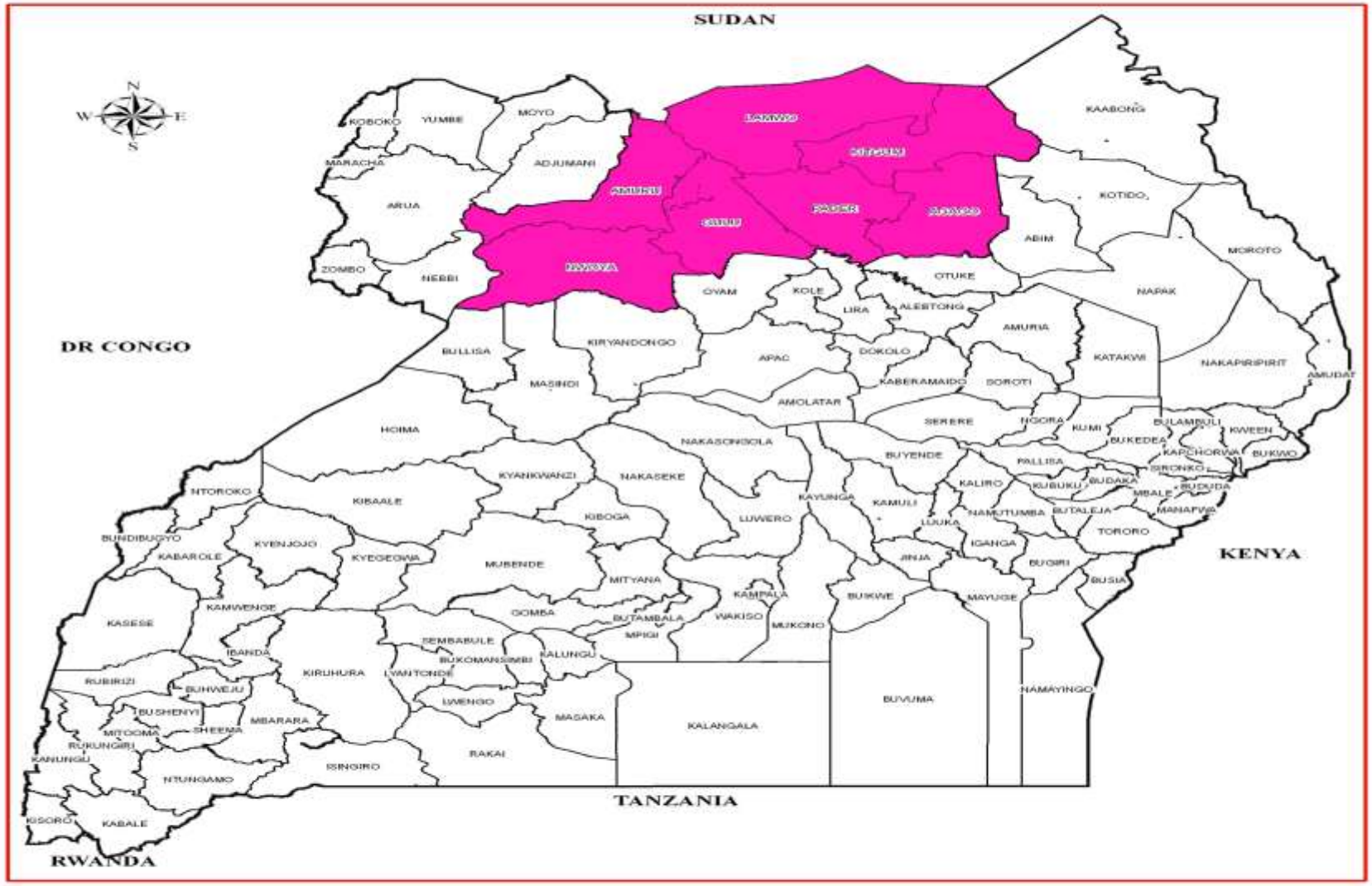
Health workers in post-conflict northern Uganda: a gender Analysis

Justine Namakula

Building back better- Health systems and gender post-conflict

Foresight Centre, Liverpool, October 20th 2015

MAP OF UGANDA SHOWING ACHOLI SUB-REGION



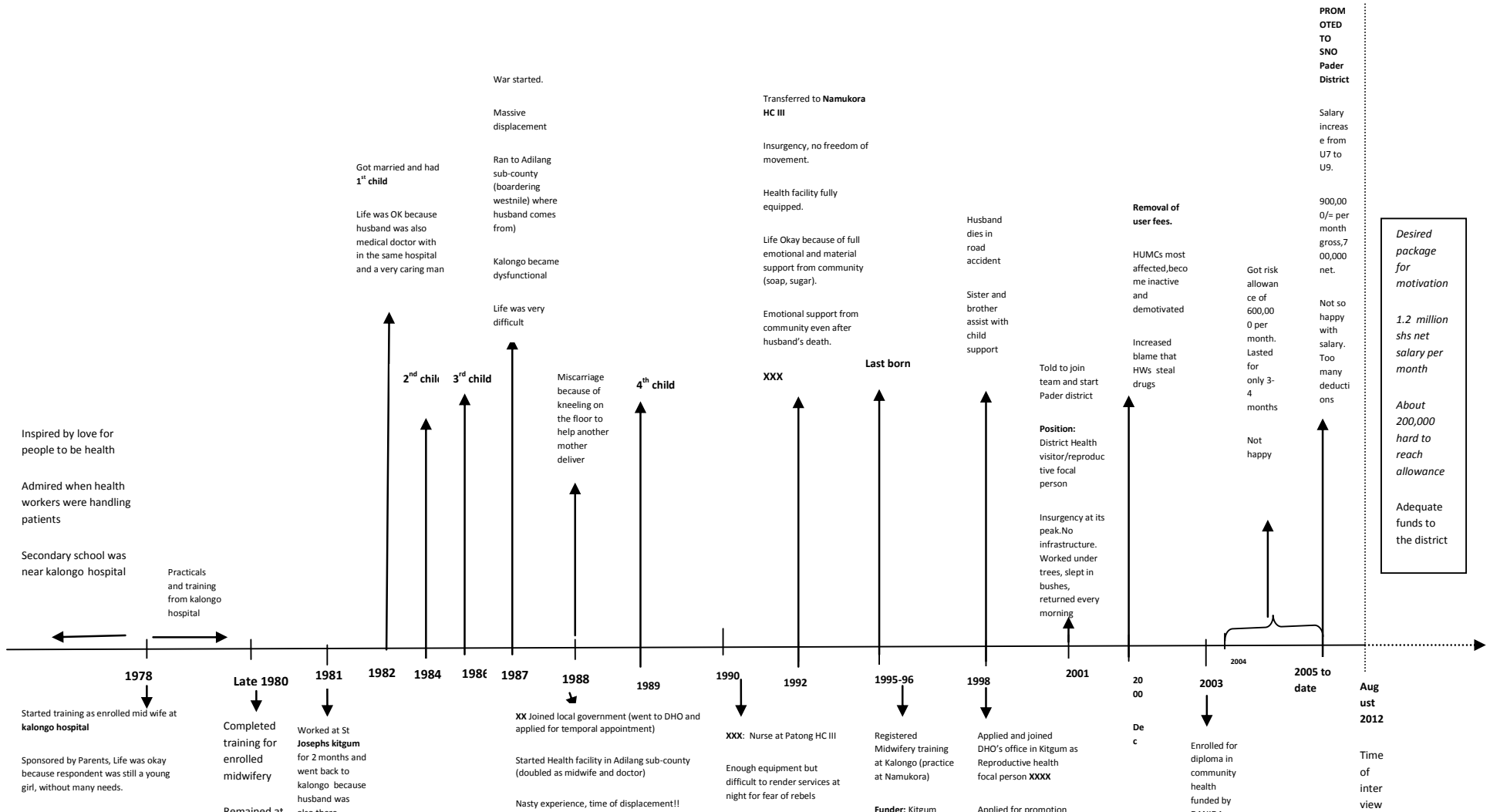
LEGEND

- Acholi Sub-Region
- Other Districts
- Uganda Boundary

UGANDA BUREAU OF STATISTICS

Plot 9, Colville Street, P.O Box 7186 Kampala.
Tel. (+256) 41 706000, Fax: 237553
Email: ubos@ubos.org, Website: www.ubos.org

Female Senior Nursing Officer




“In difficulty lies opportunity”
Einstein
Research Findings

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Who stayed?

Most Health workers who stayed during conflict in Northern Uganda were female mid-level cadres.

- Commitment under-recognised

- Gender roles= double burden for female health workers and their health work.

Access to further training

Relatively equal opportunities for further training(upgrading) but limitations for women

- Looking after orphans(of war)
- Child birth and looking after own children
-

'…unfortunately up to today I have not gone for registration because I have a lot of responsibilities, we have many orphans who lost their parents to the rebels, so with the little money I'm trying to push them ahead to study'(LH Female EN, Public HF, Gulu)

'… I was expecting my first born so I could not go for that upgrading. Then after having children, I thought of looking after them because if I was to go for upgrading, nobody would take care of them so I decided to remain'. (LH Female EM, PNFP HF, Greater Pader)

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Difficult to juggle family life and long term trainings for FHHs

[…] In 2003 I did a diploma in Community Health that was in Nairobi for 1 year […] I thought of the [young] children[left behind] and it was difficult for me as a parent. I had lost my husband in 1997 so I immediately came back from training'. (LH, Female SNO, Public HF, Pader)

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Career expectations and experiences

- Changing expectations along career paths but
- Similar coping strategies in relation to absent or low salaries
- Married females better off tha FHH and male colleagues

'… during that time (2006) … I worked for six months without payment… but my husband was assisting me…he was in Sudan …working with the NGOs. When I finally got salary, it was only 227,000 [Ush]. I had to use it just for feeding the family. With the school fees and the rest my husband used to do it because my money was too little'. (LH Female EN, Public HF, Kitgum)

- Different professional experiences
- Some unique to only women

"In Adilang, …I remember struggling to help a woman kneeling with no bed but just on the floor so that was the worst experience I had. I was also pregnant and I got a miscarriage' (LH Female SNO Public Pader)

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Implications

- Health workers commitment to serve in conflict needs recognition and tailored support
- Human resource management approaches and training opportunities need to be gender aware, responsive to life course events for workers with family responsibilities

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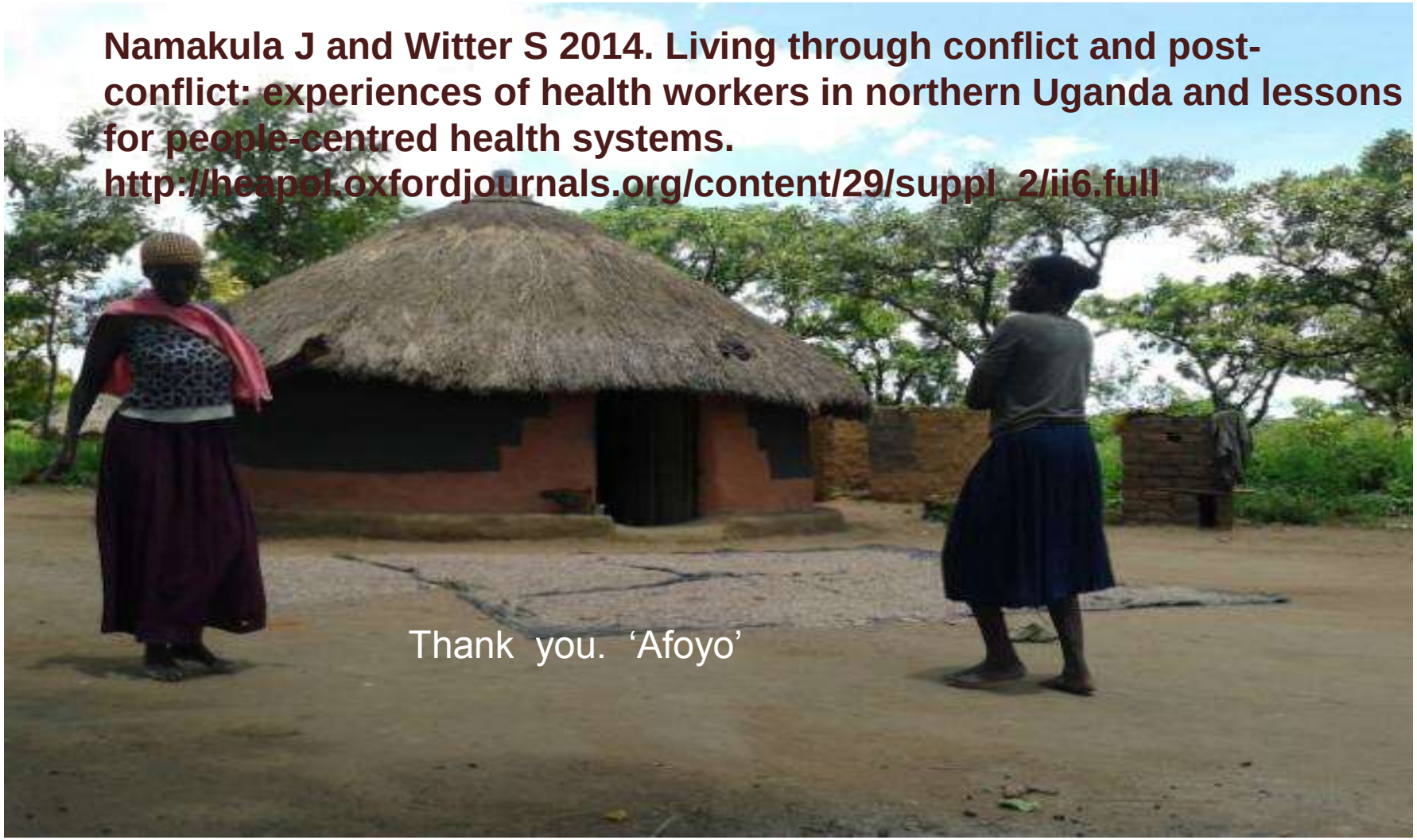

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The importance of looking at gender in post-conflict health systems strengthening

Video presentation by

Dr. Sarah Ssali

School of Women and Gender Studies

Makerere University, Uganda

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Gender and vulnerability in post-conflict societies: case of Uganda

Tim Ensor & Sarah Ssali, University of Leeds

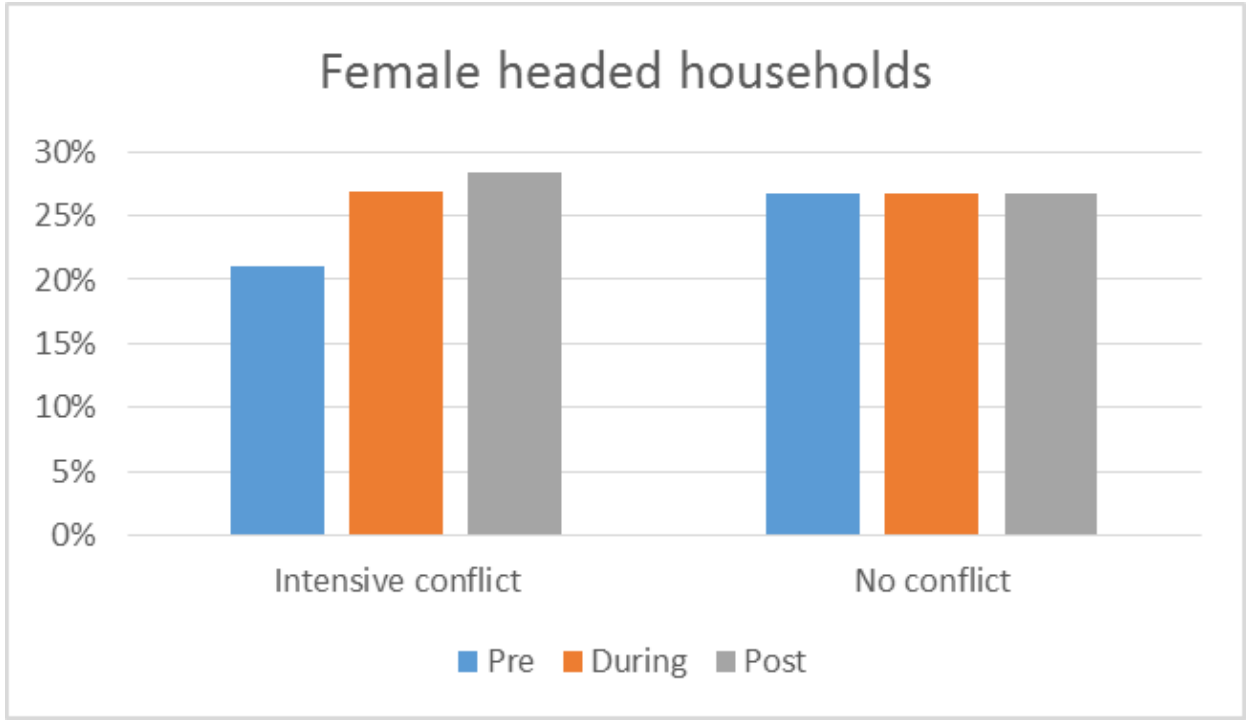
for REBUILD project 1

The impact of conflict on household composition

- Conflict causes displacement and changes to aggregate economic status of households
- It also leads to changes in the structure of households and distribution of economic wealth

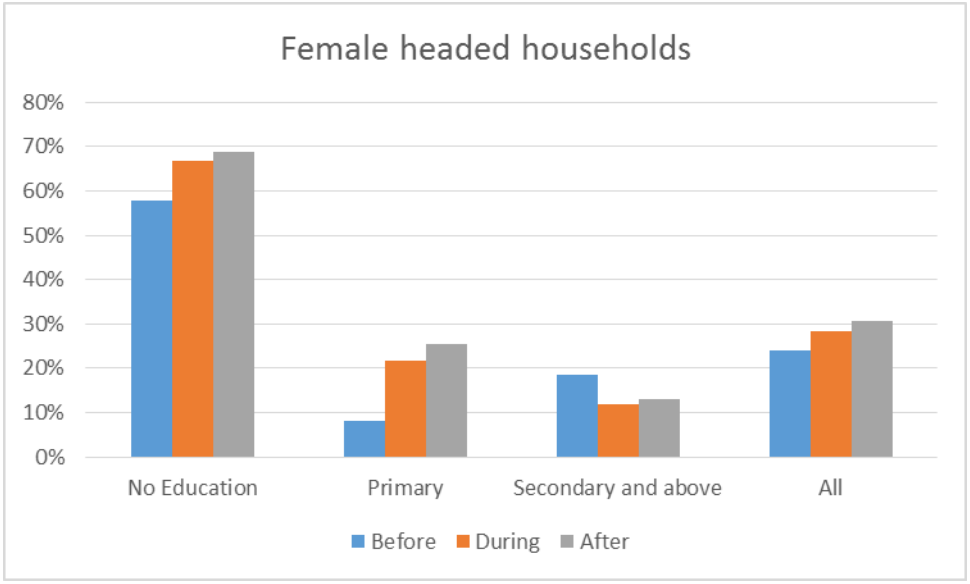
- We used multiple cross-sections of household expenditure surveys in Uganda to understand how access to health services and household vulnerability changes during conflict.
- Similar work being undertaken in Sierra Leone and Cambodia although information before conflict in these countries is extremely patchy.

Uganda: Conflict is associated with an increasing proportion of female headed households



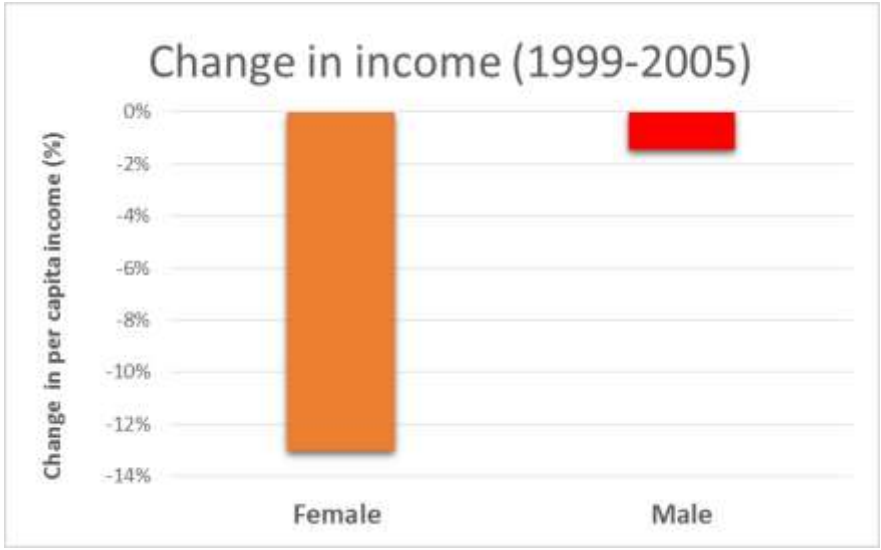
- Female headed older than male headed households (44 compared to 40)
- More likely to have elderly (over 60) members; this has increased after conflict

Education, female headed households and vulnerability

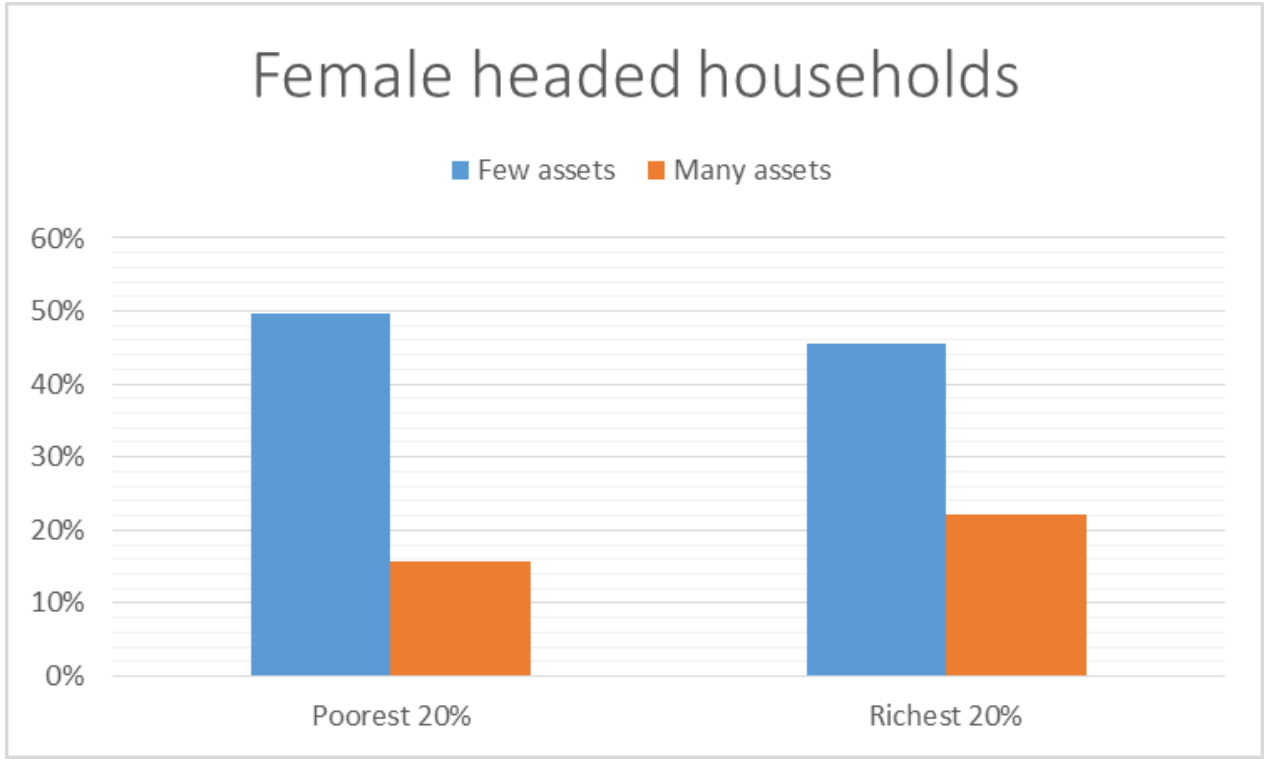


Household heads with no education are much more likely to be female. After the conflict, 38% of these were widowed compared to 13% in 1999.

Female headed households suffered a much steeper decline in income over the conflict period



Female headed households – whether rich or poor – are much less likely to have assets such as land or livestock…

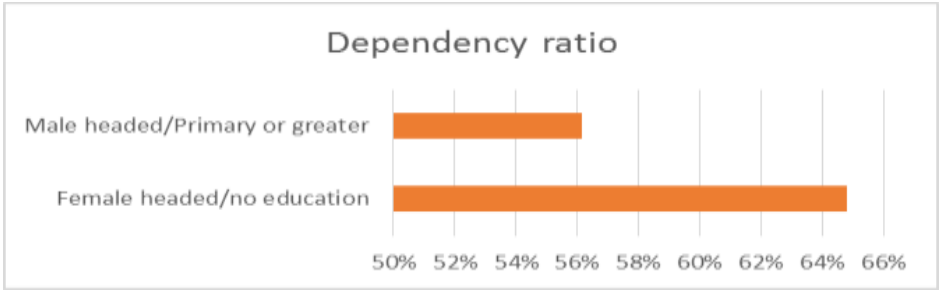


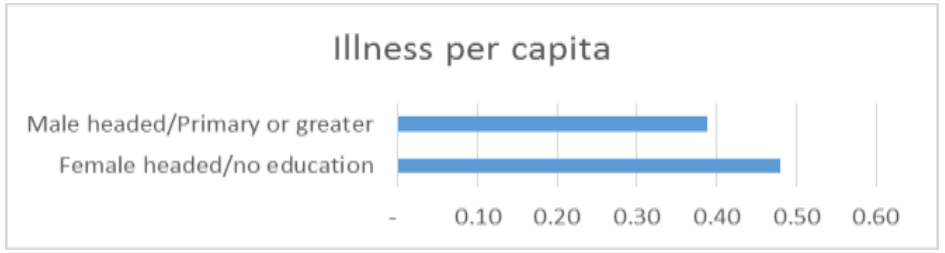
….that can be use to pay for essential services

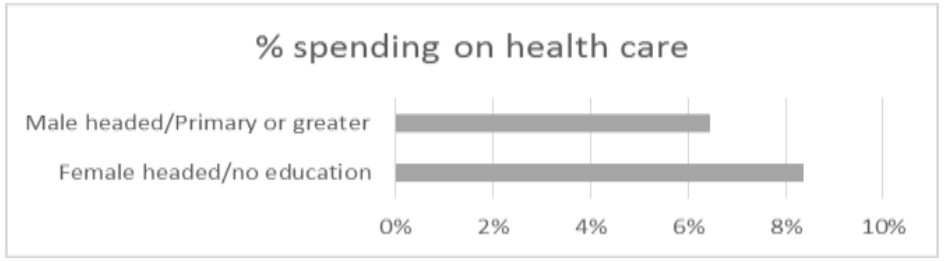
This adds up to households that are much more vulnerable

Female headed, uneducated households are:

- Have higher dependency
- Are more likely to get sick
- pay more (as a % of income) for accessing health services







Summary

- Vulnerability is associated with far more than socio-economic status
- Conflict leads to changes in household vulnerability that is particularly evident in female headed households
- Female headed households have fewer physical resources to fall back on when sickness or other crises strike
- Policy designed to overcome access barriers to health and other services need to take account of these vulnerabilities

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Panel response:

Tulip Mazumdar – Global health correspondent for BBC News

Alvaro Alonso-Garbayo – Liverpool School of Tropical Medicine

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Further information:

Building Back Better: www.buildingbackbetter.org

ReBUILD: www.rebuildconsortium.org
RinGs: http://resyst.lshtm.ac.uk/rings
NPSIA: http://carleton.ca/npsia/
TWG-FCAS: via www.healthsystemsglobal.org

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