Building Back Better
Building Better Back

How can humanitarian responses to health adequately take gender into account?

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OVERVIEW

The period just after conflict is a time of turmoil when social norms are in a state of flux, donor funds are available and there is often a political will for change. A window of opportunity for reform in public sector institutions can open, offering a chance to "build back better" in health and gender equality more broadly. It is a time when countries could theoretically establish a health system underpinned by the principles of gender equality which identifies and responds to the different health needs of women as well as men, ensuring equitable access and health outcomes.

This policy brief looks at the context of gender and health, and how they are affected by conflict. It also assesses whether humanitarian assistance in the immediate post-conflict period addresses the impact of conflict on health from a gender perspective. A second sister brief examines long-term reform of the health system through a gender lens, using the World Health Organization's health system building blocks as a framework.

KEY MESSAGES

- Conflict exacerbates existing gender inequalities and reinforces gender disparities in health.
- Measuring the impact of conflict on gender disparities in health is complex, and is hindered by poor data and a lack of consensus on relevant indicators.
- Humanitarian assistance pays lip service to integrating gender in its programming and often fails to address the different impacts of conflict on men and women.
- The humanitarian response to gender programming is dominated by a focus on sexual violence (against women) and maternal health, enabling donors and relief organisations to claim that they are addressing gender, without an understanding of how gender differences shape men and women's health in other areas.
- Humanitarian work is hindered by a lack of robust data. There is a need to collect information broken down by sex, and set indicators to measure gender disparities in health.
- The reconstruction of the health system after conflict needs to be informed by a shared vision of a gender equitable future.

TERMINOLOGY

In the literature we reviewed the terms "gender equality" and "gender equity" are used practically synonymously. In fact, their meanings are related, but distinct. Gender equality has broader social and political connotations, embracing equal rights and opportunities, whereas equity is a concept rooted in justice, parity and fairness. A gender equity approach in health acknowledges the differences between women and men – the biological and social factors which cause disparities in health – and is based not only on the principle of sameness but rather an absence of bias.

The Consolidated Appeals Process (CAP) is a tool used by humanitarian organisations to plan, implement and monitor their activities. It is the humanitarian sector's main tool for coordinating aid and action. It encourages different sectors – governmental, donor, aid agencies, the UN – to work together towards shared goals.

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METHODOLOGY

This brief is based on a literature review on the impact of health system reform on gender in developing countries, an analysis of CAPs (in Cote d'Ivoire, Haiti, Liberia, Somalia, and South Sudan), and case study research. We examined peer-reviewed and academic literature on health systems, general literature on gender and health systems, literature on gender in humanitarian assistance, reports from humanitarian organisations and primary research documents online. Sources included Google Scholar, Google, PubMed and Scopus. Terms searched in this stage of the literature review included: "health (system) reform", "gender", "equity" and "equality" and "reproductive health".

The analysis of five CAPs from 2012 provided insights into the priorities of the humanitarian community and how gender is reflected in the analysis and programming. Variables studied in the analysis of CAPs included each country's strategic objectives (including in the areas of gender and health, where available), gender issues (as identified in the needs assessment and reflected in planned activities), and projects.

One of the biggest challenges was the lack of literature on gender and health in conflict-affected and post-conflict countries. Initially research was intended to be solely on gender and health systems in countries affected by conflict or post-conflict states. However, as the lack of studies in this area became clear, the team had to broaden the scope of the research and a narrative review (a theoretical discussion of a specific topic or theme) was conducted. The CAP analysis has two limitations: not all humanitarian organisations use the CAP as a funding and coordinating mechanism, and not all the projects in CAPs actually receive funding and are implemented.

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WHAT WE FOUND

It is widely recognised that conflict magnifies gender disparities in health. During conflict, women and men suffer from sexual violence, and women are at greater risk of domestic violence. Fertility rates, unsafe abortion and maternal mortality all rise. Women have an increased need for health services due to their reproductive role, yet during the post-conflict period, the breakdown in the health system means that access to health services is disrupted.

Humanitarian responses often fail to analyse the different ways in which conflict affects men and women. While policy rhetoric stresses the importance of gender equity – in both mainstreamed and targeted initiatives –in practice gender is not adequately integrated in humanitarian programming, and gender sensitive monitoring and evaluation is rarely carried out.

However, measuring the impact of health programs on gender equity is challenging. There is a lack of consensus on the indicators of gender inequity in health, beyond a narrow focus on maternal health indicators in conflict zones. Data which is broken down by sex - to reflect the different impact of conflict on the health of men and women - is not routinely collected, especially in conflict zones. For example, the data on which the CAP analysis of gender and health is based is limited: some data appears unreliable; for example in Liberia the life expectancy of men and women was recorded as the same which is clearly an error. To reflect the differential burden of conflict on men and women, a mix of quantitative and qualitative indicators are needed, as well as consultations with people affected by conflict, especially women.

Getting humanitarian programming right is critical as health systems are path dependent – decisions taken in the immediate post-conflict period have lasting ramifications for the functioning and equity of the health system.

Engagement in health in countries emerging from conflict should ideally: (1) identify the different health needs and health outcomes of men and women; (2) understand the factors underlying these differences, and (3) respond effectively to these differences both in the provision of health care and the health system itself. Our analysis of five CAPs showed that the humanitarian response is constrained by a shortage of data, particularly data which is broken down by sex, analysis of the impact of conflict on gender, and how gender influences health. 'Gender'

programming generally, and in health, equates to a medical focus on maternal health and sexual violence against women (while neglecting sexual violence against men). Although these programmes are important, the impact of gender on health transcends this narrow perspective. Overlooking gender concerns in the humanitarian response is a missed opportunity to influence future health systems.

Two critical interventions in the humanitarian response can have a lasting effect on health systems: quantitative and qualitative health surveys to ensure that health programmes after crisis are informed by evidence; and the production of a document outlining a vision for the future health system. This vision document is key: if it limits gender equity to the narrow perspective of maternal health and sexual violence, a vital opportunity to 'build back better' may be missed.

Overall, health system research is 'gender blind': there is no agreed definition of what is encompassed by the term 'gender equitable health system' and how to build it. Without a definition, building a health system that is equitable for women as well as men is challenging.

In order to build health systems that are gender equitable, decision makers need to understand the wider context of gender and health, how they interact, and to consider health systems through a gender lens. Men and women have different health outcomes which are influenced not only by their biology but by pervasive gender norms and discrimination. The Women and Gender Equity Knowledge Network lists four categories of gender inequalities which undermine women's health: discriminatory values, practices and behaviours; different vulnerabilities to disease and injuries; biases in health systems; and biases in health research.

In the absence of an approach that considers the relationship between gender, health and conflict, humanitarian efforts in countries emerging from conflict will remain limited. What's more, policy-makers will miss an opportunity to introduce key social reforms in the immediate aftermath of war: a critical time that can shape the long-term development of the health system.

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ABOUT THIS BRIEF

This is the first of two policy briefs to communicate the findings of the Building Back Better research initiative undertaken by the Stockholm International Peace Research Institute (SIPRI) working group on gender, the ReBUILD Consortium, and Research in Gender and Ethics: Building stronger health systems (RinGs). It explores whether international efforts to rebuild health systems in post-conflict countries address gender equity concerns. This research was conducted by Val Percival (Norman Paterson School of International Affairs, Carleton University), Tammy MacLean (London School of Hygiene and Tropical Medicine), Sally Theobald and Esther Richards (both Liverpool School of Tropical Medicine). The brief was edited by Kate Hawkins and Sarah Hyde. If you would like to find out more please contact Valerie.percival@carleton.ca

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The second brief in this series is Building Back Better: How can health system reform after conflict support gender equity?

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