

Building Back Better Building Better Back

How can health system reform after conflict support gender equity?



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OVERVIEW

A common assumption is that strengthening the health system will automatically lead to better health for men and women. However, health systems are not neutral: they reflect gender norms, and as such, can reinforce gender inequalities and discrimination. Health system reform has largely paid little attention to how health service integration, human resource policies, information systems and financing affect gender equity and women as well as men. Without such an analysis, health reform can have a negative impact on women's health and access to services. Moreover, integrating gender equity into health system reform could be a tool to promote gender equality throughout society.

This brief examines the reform of health systems in post-conflict settings through a gender lens, using the World Health Organization's health system building blocks as a framework. Research into the importance of reconstructing health systems after a crisis or war is relatively new, therefore literature discussing challenges and best practices related to gender equity is weak and the evidence base limited. Further study is clearly needed into the impact of strengthening the health system on gender equity.

KEY MESSAGES

- The impact of health system reform on gender equity in post-conflict countries has largely been overlooked. This is a missed opportunity amid the policy and programmatic options created by donor resources and the social and political flux of the early post-conflict phase.
- Priority areas for action include promoting gender equity for women in the health workforce, ensuring financing mechanisms are gender equitable, and ensuring leadership for gender equity during health system reform. These are vital in all settings, but particularly after conflict, where a window of opportunity exists for social reform and change such as the advancement of women to health leadership positions.
- Action in this area will not only have repercussions for the promotion of gender equity in health, but also for the foundation of gender equality in society which in turn contributes to social well-being and increased security and peacebuilding.

METHODOLOGY

This brief is based on a review of the literature on health system reconstruction in countries affected by conflict, in post-conflict settings and in low- and middle-income countries. Four case studies were also constructed in order to test the general findings from the literature review.

The review examined peer-reviewed and academic literature on health systems, general literature on gender and health systems, reports from humanitarian organisations and primary research documents online. Most studies were reviews or frameworks on gender and health, with few papers summarising the results of household surveys or interviews. Sources included Google Scholar, Google, PubMed and Scopus. Terms searched in the review included: "health (system) reform", "gender", "equity" and "equality" and "reproductive health". Searches were carried out based on WHO's framework of health system components, such as medical products and technologies (terms: "pharmaceuticals and gender" and "medical technologies and gender") and health system financing (terms: "social insurance and gender", "gender budgets"). A search also examined links between women and peacebuilding, and gender, social well-being and peace.

Initially research was intended to focus solely on gender and health systems in countries affected by conflict and post-conflict states. However, as the lack of studies in this area became clear, the scope of the literature review was widened to encompass the impact of health system reform on gender in low- and middle-income countries more generally. One of the biggest challenges was the lack of health systems literature that examined the impact of health programming on gender equity in conflict-affected and post-conflict countries. Due to the novelty of the research area a narrative review was undertaken.



WHAT WE FOUND

Health systems can be powerful tools to enhance gender equity in health. However, their potential has to date been hindered by a number of factors. Firstly, the overwhelming focus on sexual violence (against women, violence against men and other genders remains under-prioritised) and maternal health in humanitarian programming on gender has meant that other elements of gender and health have been under-explored.

Secondly, research into health reform in post-conflict countries tends to be 'gender blind' – it has not identified the different health issues facing men and women or analysed how health systems respond to these differences. There is no shared definition of what a gender equitable health system looks like nor is there clarity on indicators to measure gender disparities in health.

Thirdly, the narrow guidance provided by UN Security Council Resolution 1325 on Women, Peace and Security and follow-up resolutions limit women's role to peace and political processes rather than involvement in the reconstruction of the health system. The only indicator to measure access to health services is maternal mortality.

The World Health Organisation identifies six building blocks that make up health systems: 1) health service delivery 2) human resources 3) health information systems 4) health system financing 5) medical products and technologies and 6) leadership and governance. Some of these core components are cross-cutting, such as leadership and governance and health information systems. Gender is conspicuous in its absence.

Under each of these building blocks there is a need to consider gender in the process of health system reform:

Health service delivery: there is a lack of research into the impact of integrating health services on gender equitable health. For example, studies show that the basic package of health services (BPHS) does not always include comprehensive reproductive health services for all women and adolescent girls.

Health workforce: women primarily work in service delivery roles in the health system, such as nursing and midwifery, rather than senior roles that command more respect and pay. Women are affected by recruitment, retention, retraining and promotion strategies in the health workforce, and yet they tend not to be consulted in human resource planning.

Health information systems: breaking down data by sex, age and income is crucial for the promotion of equity in health systems. However, weak information systems in countries affected by crisis means that this data is not routinely collected and there is a lack of agreement on the best indicators to measure the impact of health reform on gender equity.

Health system financing: scarce information exists on how financing mechanisms affect the different health needs of men and women. Tax-based financing of universal access to essential health services can foster equitable access among lower-income groups, benefiting women who constitute the majority of the poor. User fees can decrease women's use of services, and social and private insurance schemes often exclude women who disproportionately work in the informal economy or cannot afford higher premiums.

Medical products and technologies: from childhood, gender bias influences girls' and boys' access to medicine, and gender disparities play a role in the diagnosis of disease among men and women. For example, there is evidence of barriers that impact on TB diagnosis among women.

Leadership and governance: promoting women's voices in health reform is critical - when men set the agenda for health care, evidence shows that women's health needs are not reflected in local health priorities or resources. Decentralising health services, a common public service reform in post-conflict settings, can have a negative impact on the quality of all health services, and impact on gender equitable goals and objectives. Reforming the health system to respond to the needs of women as well as men is important not only for the health benefits for both sexes: it can



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have positive repercussions for broader gender equality in society. Evidence suggests that gender equality can contribute to a state's improved security and peacebuilding. Now is the time for researchers and advocates to provide clear evidence, guidance and indicators to help policy-makers 'build back better' after war and crisis.

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ABOUT THIS BRIEF

This is the second 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 looks at whether international engagement to rebuild health systems in post-conflict countries addresses gender equity concerns and results in gender equitable health systems. 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 first brief in this series is Building Better Back: How can humanitarian responses to health adequately take gender into account?

